SUBURBAN BEHAVIORAL HEALTH SERVICES

SBHS
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Oakbrook Terrace, IL 60181
Phone (630) 613-9800
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Therapy Questionnaire

Today's Date: 07/10/2017

Patient's First Name Last Name Date of Birth

Have you been in therapy previously? ◯ Yes ◯ No When? _____

Reason for ending therapy? _____

What medications are you taking? _____

Prescribing Physician? _____

Would you like us to coordinate care? ◯ Yes ◯ No Physician's Number _____

Have you had any recent hospitalizations? _____

Any past hospitalizations? _____

Do you have a history of physical, emotional or sexual abuse? _____

Health & Social Information

Do you have a stable living environment and who do you currently live with? _____

Are you currently in a romantic relationship? ◯ Yes ◯ No How long? _____

How would you rate the quality of your relationship? 10 Children? ◯ Yes ◯ No

If you are seeking marital counseling, how long have you been experiencing difficulties? _____

If you are seeking marital counseling, how long have you been experiencing difficulties?

◯ Poor ◯ Unsatisfactory ◯ Satisfactory ◯ Good ◯ Very Good

Please list any persistent physical symptoms or health concerns (i.e. chronic pain, diabetes, headaches)

_____

Are you having any difficulties with sleeping? _____

Average hours of sleep per night? _____

Do you exercise throughout the week, if so, how often? _____

Are you having any difficulties with your appetite or eating habits? ◯ No ◯ Yes please specify:

☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting

Have you experienced significant weight change in the last 2 months? ◯ Yes ◯ No

specify: _____

Do you regularly use alcohol? ◯ Yes ◯ No How often? _____

Do you engage in recreational drug use? ◯ Yes ◯ No How often? _____

Have you had suicidal thoughts in the past 6 months? choose where applicable

◯ Daily ◯ Weekly ◯ Monthly ◯ Not in the last 6 months ◯ Never

Have you had suicidal thoughts in the past? ◯ No ◯ Yes When? _____

Have you in the past, or currently engage in self-harm behaviors? ◯ Yes ◯ No

Last episode _____

Please choose any symptoms you've experienced in the past or present:

☐ Depressed mood ☐ Mood Swings ☐ Phobia ☐ Anxiety

☐ Impulsivity ☐ Panic Attacks ☐ Hallucinations ☐ Eating Disorder

☐ Homicidal Thoughts ☐ Anger ☐ Body Image Concerns ☐ Trauma

☐ Social Anxiety ☐ Bullying ☐ Alcohol/Substance Abuse ☐ Identity Issues

Any family history of the following:

☐ Depressed mood ☐ Anxiety ☐ Schizophrenia

☐ Suicide Attempts ☐ Bipolar Disorder ☐ Trauma History

☐ Alcohol/Substance Abuse ☐ Eating Disorder

Please briefly describe why you are seeking therapy at this time and what you would like to address in therapy.

Any goals you have for yourself:

Current coping skill that help you:

Who would you consider to be your support(s)?

Patient's Full Name Signature Date

Reset Form Submit Form