

PATIENT INFORMATION QUESTIONNAIRE

This form is confidential and is designed to help your healthcare professional organize and gather information about you, your history, and the concerns that have led you to seek treatment. Please fill out as much as you are able. If, for any reason, you would rather not answer certain questions, feel free to leave them blank or write in “need to discuss.” Thank you.

PERSONAL & CONTACT INFORMATION

NAME:	
SSN:	
DOB:	GENDER:
HOME ADDRESS:	
<input type="checkbox"/> Okay to receive mail here	
MAILING ADDRESS (IF DIFFERENT FROM ABOVE):	
<input type="checkbox"/> Okay to receive mail here	
HOME PHONE:	<input type="checkbox"/> Okay to phone <input type="checkbox"/> Okay to leave message
CELL PHONE:	<input type="checkbox"/> Okay to phone <input type="checkbox"/> Okay to leave message
OTHER PHONE:	<input type="checkbox"/> Okay to phone <input type="checkbox"/> Okay to leave message
PREFERRED EMAIL ADDRESS: (PLEASE BE AWARE THAT EMAIL IS NOT A SECURE MEANS OF COMMUNICATION)	
PREFERRED METHOD OF CONTACT:	
<input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> Other	
HOW DID YOU HEAR ABOUT THE CLINIC?	
<input type="checkbox"/> Medical Referral <input type="checkbox"/> Webpage <input type="checkbox"/> Psychology Today <input type="checkbox"/> Presentation	
<input type="checkbox"/> Friend or Family <input type="checkbox"/> Mental Health Referral	
<input type="checkbox"/> Other:	
RELATIONSHIP STATUS:	

SEXUAL ORIENTATION:

RACE/ETHNICITY:

LANGUAGE(S) SPOKEN:

RELIGIOUS OR SPIRITUAL AFFILIATION:

ARE YOU CURRENTLY ACTIVE IN YOUR RELIGION?

PRESENTING PROBLEM

PLEASE STATE BRIEFLY WHAT HAS PROMPTED YOU TO SEEK TREATMENT AT THIS TIME?

HOW LONG HAVE YOU BEEN EXPERIENCING THIS PROBLEM(S)?

PLEASE IDENTIFY ANY OF THE BELOW THAT ARE OF CONCERN AT THIS TIME (PLEASE CHECK ALL THAT APPLY):

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Fatigue / low energy <input type="checkbox"/> Procrastination <input type="checkbox"/> Burnout <input type="checkbox"/> Motivation <input type="checkbox"/> Academic / Work Concerns <input type="checkbox"/> Assertiveness <input type="checkbox"/> Trouble Concentrating <input type="checkbox"/> Stress Management <input type="checkbox"/> Athletic Performance <input type="checkbox"/> Perfectionism <input type="checkbox"/> Self-Esteem <input type="checkbox"/> Decision Making <input type="checkbox"/> Learning Problems <input type="checkbox"/> Phobias <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Nightmares <input type="checkbox"/> Anger Issues <input type="checkbox"/> Feeling Guilty | <ul style="list-style-type: none"> <input type="checkbox"/> Relationship Concerns <input type="checkbox"/> Relationship Conflict <input type="checkbox"/> Infidelity <input type="checkbox"/> Family Problems <input type="checkbox"/> Sexual Health Concerns <input type="checkbox"/> Life Transition <input type="checkbox"/> Infertility Concerns <input type="checkbox"/> Physical Abuse / Assault <input type="checkbox"/> Sexual Abuse / Assault <input type="checkbox"/> Cultural Concerns <input type="checkbox"/> Sexual Orientation <input type="checkbox"/> Gender Identity <input type="checkbox"/> Personal Growth <input type="checkbox"/> Clarification of Values <input type="checkbox"/> Diet and Weight Loss <input type="checkbox"/> Disordered Eating <input type="checkbox"/> Shyness <input type="checkbox"/> Loneliness <input type="checkbox"/> Spiritual or Religious Concerns | <ul style="list-style-type: none"> <input type="checkbox"/> Paranoia <input type="checkbox"/> Loss or Grief <input type="checkbox"/> Alcohol or Drug Concerns <input type="checkbox"/> Injury Recovery / Rehab <input type="checkbox"/> Legal Concerns <input type="checkbox"/> Compulsive Behavior <input type="checkbox"/> Feelings of detachment / unreality <input type="checkbox"/> Intrusive Upsetting Thoughts <input type="checkbox"/> Intrusive Upsetting Memories <input type="checkbox"/> Cutting or Self Injury <input type="checkbox"/> Thoughts of Suicide <input type="checkbox"/> Medical / Health Concerns <input type="checkbox"/> Mood Swings <input type="checkbox"/> Trauma <input type="checkbox"/> Depressed Mood <input type="checkbox"/> Anxiety <input type="checkbox"/> Episodes of Manic Behavior <input type="checkbox"/> Obsessive Thoughts <input type="checkbox"/> Racing Thoughts |
|---|--|---|

OUT OF THE ITEMS CHECKED ABOVE, PLEASE LIST YOUR TOP 3 CONCERNS IN ORDER OF IMPORTANCE:

- 1.
- 2.
- 3.

HOW WOULD YOU RATE YOUR CURRENT LEVEL OF DISTRESS REGARDING THE CONCERNS YOU LISTED ABOVE?

MINIMAL			MODERATE				SEVERE		
1	2	3	4	5	6	7	8	9	10

PLEASE RATE TO WHAT DEGREE YOUR CONCERN(S) AFFECT YOUR DAY-TO-DAY FUNCTIONING:

MINIMAL			MODERATE				SEVERE		
1	2	3	4	5	6	7	8	9	10

EDUCATION & WORK HISTORY

HIGHEST EDUCATION COMPLETED:

- | | |
|---|---|
| <input type="checkbox"/> Some High School
<input type="checkbox"/> High School Diploma
<input type="checkbox"/> Some College
<input type="checkbox"/> Associate's Degree | <input type="checkbox"/> Bachelor's Degree
<input type="checkbox"/> Some Graduate School
<input type="checkbox"/> Master's Degree
<input type="checkbox"/> Doctoral Degree |
|---|---|

WHAT TYPE OF GRADES DID YOU TYPICALLY GET IN SCHOOL?

HAVE YOU BEEN DIAGNOSED WITH A LEARNING DISABILITY? Yes No

HAVE YOU EVER SUSPECTED YOU MAY HAVE A LEARNING DISABILITY? Yes No

ARE YOU CURRENTLY EMPLOYED? Yes No

JOB TITLE / DESCRIPTION:

HOW LONG HAVE YOU BEEN AT YOUR CURRENT POSITION?

APPROXIMATELY HOW MANY JOBS HAE YOU HAD IN YOUR ADULT LIFE?

FAMILY HISTORY

WHERE WERE YOU BORN?

WERE YOU ADOPTED? Yes No

If yes, do you have any knowledge of your birth family?

WHERE DID YOU GROW UP?

HOW MANY TIMES DID YOU MOVE BEFORE YOU WERE 18 YEARS OLD?

DID YOUR PARENTS DIVORCE OR SEPARATE? Yes No

If yes, how old were you at the time?

PLEASE LIST THE (FIRST) NAMES AND AGES OF YOUR IMMEDIATE FAMILY MEMBERS (E.G., PARENTS, SIBLINGS, CHILDREN, GRANDCHILDREN, GRANDPARENTS, SIGNIFICANT CARETAKERS):

NAME	RELATIONSHIP	AGE	QUALITY OF RELATIONSHIP
EXAMPLE: <i>JACOB</i>	<i>FATHER</i>	<i>74</i>	<i>OKAY</i>

**HAS ANYONE IN YOUR IMMEDIATE (PARENTS, SIBLINGS, CHILDREN) OR EXTENDED FAMILY (GRANDPARENTS, COUSINS, ETC.) BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?
OR DO YOU SUSPECT THAT THEY MAY HAVE ANY OF THE FOLLOWING?**

- | | |
|--|--|
| <input type="checkbox"/> Disordered Eating | <input type="checkbox"/> Anxiety, fears, phobias |
| <input type="checkbox"/> Attention problems or ADD/ADHD | <input type="checkbox"/> Bipolar Disorder / Manic Depression |
| <input type="checkbox"/> Addiction issues (alcohol, drugs, gambling) | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Other |

If you checked any of the above, please elaborate briefly:

MEDICAL HISTORY

DATE OF LAST PHYSICAL EXAM:

RESULTS OF EXAM:

HAVE YOU EVER BEEN HOSPITALIZED FOR A MEDICAL CONDITION? Yes No

If yes, please explain:

HAVE YOU EVER SUFFERED A SEVERE HEAD INJURY WITH LOSS OF CONSCIOUSNESS OR CONCUSSION? Yes No

If yes, please explain:

DO YOU HAVE CHRONIC PAIN? Yes No

If yes, please explain:

PLEASE LIST PAST AND PRESENT MEDICAL CONDITIONS, PROBLEMS AND/OR DIAGNOSES:

PRIMARY CARE PROVIDER (NAME, PHONE, ADDRESS):

PSYCHIATRIST / PSYCHOLOGIST / PSYCHOTHERAPIST (NAME, PHONE, ADDRESS):

PLEASE LIST ALL MEDICATIONS (AND DOSAGE) YOU ARE CURRENTLY TAKING (PLEASE INCLUDE PRESCRIPTION MEDICATION, OVER-THE-COUNTER MEDICATION, VITAMINS, ORAL CONTRACEPTIVES AND ALTERNATIVE REMEDIES):

PLEASE LIST ALL PSYCHOTROPIC MEDICATIONS YOU HAVE TAKEN IN THE PAST, IF ANY (PLEASE INCLUDE DOSAGE, DATES OF USE AND ANY SIDE EFFECTS):

HISTORY OF:	CHECK ONE:	IF YES, PLEASE EXPLAIN BELOW, INCLUDING DATES IF APPROPRIATE:
Neurologic disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizure disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Respiratory disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiovascular disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hematopoietic-lymphatic disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eyes/Ears/Nose/Throat Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatic Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dermatologic Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Musculoskeletal Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Endocrine-Metabolic Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastrointestinal Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Renal-Genitourinary Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sexual Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Malignancies	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies or Drug Sensitivities	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Major Surgical Procedures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vision problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sexually Transmitted Disease(s) / Infection(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Daytime Sleepiness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Difficulty Sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Unusual Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Memory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Recurring Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Serious Head Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Substance Abuse History	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other-General	<input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICAL HISTORY CONTINUED

WERE THERE ANY COMPLICATIONS AT YOUR BIRTH? (E.G., *PREMATURE BIRTH, MEDICAL PROBLEMS*) Yes No

If yes, please explain:

DID YOU EXPERIENCE ANY PROBLEMS IN YOUR EARLY DEVELOPMENT (E.G., *LEARNING TO WALK, TALK, ETC.*)?

Yes No

If yes, please explain:

-FOR FEMALE PATIENTS-

AGE OF FIRST PERIOD:

HOW MANY TOTAL PREGNANCIES HAVE YOU HAD?

HOW MANY TOTAL PREGNANCIES HAVE YOU CARRIED TO TERM?

WHICH BEST DESCRIBES YOUR MENSTRUAL CYCLE NOW?

- Regular
- Irregular
- Pre-menopausal
- Menopausal
- Post-Menopausal

RELATIONSHIP HISTORY

AGE AT FIRST SIGNIFICANT ROMANTIC RELATIONSHIP:

TOTAL NUMBER OF MARRIAGES / LONG TERM (OVER 1 YEAR) RELATIONSHIPS:

IF YOU ARE MARRIED / PARTNERED, PLEASE BRIEFLY DESCRIBE YOUR RELATIONSHIP:

IF YOU ARE CURRENTLY SINGLE, DIVORCED, SEPARATED OR WIDOWED, PLEASE BRIEFLY DESCRIBE YOUR LAST LONG TERM RELATIONSHIP:

MENTAL HEALTH HISTORY

HAVE YOU EVER SOUGHT MENTAL HEALTH TREATMENT? Yes No

If yes, please complete the following about your past (or present) treatment experience(s)

PROVIDER NAME:	PROVIDER CONTACT INFO:	APPROXIMATE DATES:	PROBLEM(S) ADDRESSED?	WAS TREATMENT HELPFUL?

HAVE YOU EVER BEEN HOSPITALIZED FOR A PSYCHIATRIC CONDITION? Yes No

If yes, please describe the circumstances of your hospitalization (how long, name of facility, dates):

HAVE YOU EVER BEEN ADMITTED TO RESIDENTIAL OR INTENSIVE OUTPATIENT TREATMENT? Yes No

If yes, please describe the circumstances of your treatment (how long, name of facility, dates):

DO YOU USE TOBACCO? Yes No

If yes, please indicate the amount and frequency:

HOW MANY BEVERAGES CONTAINING ALCOHOL DO YOU CONSUME IN A TYPICAL WEEK?

HOW MANY BEVERAGES CONTAINING CAFFEINE DO YOU CONSUME IN A TYPICAL DAY?

HAVE YOU USED ANY DRUGS IN THE PAST 30 DAYS THAT WERE NOT PRESCRIBED BY A HEALTHCARE PROFESSIONAL (E.G., MARIJUANA, HASH, COCAINE, ADDERALL, DIET PILLS, ECSTASY, VALIUM, LSD, ACID, MUSHROOMS, HEROIN, VICODIN, CODEINE, OR OTHER)? Yes No

If yes, please describe (including the amount and frequency):

HAS ANYONE EVER SUGGESTED YOU DRINK ALCOHOL OR USE DRUGS TO EXCESS? Yes No

HAVE YOU EVER BEEN IN TREATMENT FOR SUBSTANCE AND/OR ALCOHOL USE? Yes No

If yes, please describe the circumstances of your treatment (how long, name of facility, dates):

APPROXIMATELY HOW MANY HOURS PER DAY DO YOU SPEND ONLINE?

SOCIAL NETWORKING SITES	
YOUTUBE	
GAMING	
BROWSING	
SHOPPING	
GAMBLING	
PORNOGRAPHY SITES	
OTHER	

DO YOU FEEL YOUR TECHNOLOGY USE IS BALANCED? Yes No

DO YOU EVER HAVE PROBLEMS CONTROLLING THE AMOUNT OF FOOD YOU EAT? Yes No

If yes, please describe:

HOW MANY TIMES PER YEAR DO YOU GAMBLE (ONLINE OR OTHER)?

HAVE YOU EVER HAD THOUGHTS OF HARMING YOURSELF? Yes No

If yes, please describe the types of thoughts (including frequency, intensity and duration):

HAVE YOU EVER PURPOSELY INJURED YOURSELF WITHOUT SUICIDAL INTENT (E.G., CUTTING, HITTING, BURNING)?

Yes No

If yes, please describe the types of behavior(s) (including frequency, intensity and duration):

IN THE PAST FEW WEEKS, HAVE YOU HAD THOUGHTS OF SUICIDE? Yes No

If yes, please describe the types of thoughts (including frequency, intensity and duration) and whether you have acted on these thoughts:

HAVE YOU SERIOUSLY CONSIDERED SUICIDE IN THE PAST? Yes No

If yes, please describe:

HAVE YOU EVER ATTEMPTED SUICIDE? Yes No

If yes, please describe:

HAVE YOU EVER SERIOUSLY CONSIDERED HARMING ANOTHER PERSON? Yes No

If yes, please describe:

HAVE YOU EVER INTENTIONALLY PHYSICALLY HARMED ANOTHER PERSON? Yes No

If yes, please describe:

<p>DO YOU CURRENTLY HAVE THOUGHTS OF HARMING ANOTHER PERSON? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p>
<p>HAS ANYONE IN YOUR FAMILY ATTEMPTED OR COMMITTED SUICIDE? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p>
<p>DO YOU CURRENTLY HAVE ACCESS TO ANY WEAPONS, INCLUDING FIREARMS? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p>

LEGAL HISTORY

<p>HAVE YOU EVER BEEN ARRESTED OR CONVICTED OF A CRIME? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe (including when):</p>
<p>ARE YOU PRESENTLY INVOLVED IN A LAWSUIT? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p>
<p>ARE YOU SEEKING TREATMENT DUE TO AN ACCIDENT OR INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p>
<p>ARE YOU REQUIRED BY A COURT, THE POLICE OR A PROBATION/PAROLE OFFICER TO BE IN TREATMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p>

REFLECTIONS

<p>WHAT GIVES YOU THE MOST PLEASURE IN YOUR LIFE?</p>
<p>WHAT ARE YOUR MAIN WORRIES OR FEARS?</p>
<p>WHAT ARE YOUR MOST IMPORTANT HOPES AND DREAMS?</p>

OTHER

IS THERE ANYTHING ELSE YOU WOULD LIKE YOUR HEALTHCARE PROFESSIONAL TO KNOW?

THE CLINIC
912 COLE STREET, #368
SAN FRANCISCO, CA 94117
WWW.THECLINICCA.ORG

PH 415-843-1523

FAX 415-484-7083