Chart # ________________

MIDWEST CENTER FOR PSYCHOTHERAPY & SEX THERAPY

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Date: ____________________ **Your Name:** ____

This questionnaire is to help us understand you and your needs. It will be used by us and will not be made available to anyone outside this office without your written permission, except for purposes of licensure audit.

1. Marital or relationship status? ________________________________ 2. How long? ____________________

3. Children: Age: ________ Sex: ________ Age: ________ Sex: ________ Age: ________ Sex: ________

________ ________ ________ ________ ________ ________

________ ________ ________ ________ ________ ________

4. Occupation ________________________________ How long? ______________________________

5. Living Arrangement ____

6. How did you choose us? ____

7. Were you referred to us by anyone? __________ By whom? ________________________________

8. Have you ever been in therapy / counseling before? __________ If yes, when? ____________________

Where? ___________________________ With Whom? ______________________________

9. Have you ever been hospitalized for emotional problems? __________ If yes, when? ________________

Where? ____

For how long? ____

10. Are you currently taking any medication(s)? __________ If yes, name of medication(s)? ________________

____

Amount taken ____

Physician's name ____

11. Are you allergic to any medication? ____________ If yes, what? ______________________________

12. Name and address of personal physician ____

____

13. Do you have any medical problems? __________ If yes, please describe: ________________________

____

(over)

14. In the last year, have you experienced changes in sleep? ______________ Appetite? ______________ Concentration? _________

Memory? _______________ When? ____

15. Have you been feeling like harming yourself? ___________ Have you seriously thought about suicide? _____________________

Have you ever attempted suicide? ___________ When? ____

16. Are you feeling depressed (sad) more often than usual? _______________ Nervous or tense? ______________________________

17. Do you have mood swings? ____

18. Do you ever have experiences hearing or seeing things that other people might not? _______________________________________

19. Do you feel people are trying to harm you or are following or watching you? ____

20. Are you bothered by any thoughts or actions you cannot control? ____

21. Do you feel you have a problem with alcohol or drugs? _____________________ Do others feel you do? ___________________

22. Have there been any major changes in your life within the last year? (For example: new job, change in relationship status, death in the family)____

____

23. Please summarize briefly what problems you are having that brought you to Midwest Center for Psychotherapy and Sex Therapy

____

____

24. Please summarize how you / your life might be different if these problems were resolved in therapy_________________________

____

____

25. Please list those qualities or skills you see as your strengths ____

____

____

26. Is there anything else you feel we should know that would help us in working with you? __________________________________

____

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