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ALL NEW PATIENTS ARE ENCOURAGED TO FILL OUT THIS FORM BEFORE THE FIRST SESSION. YOUR INFORMATION IS CONFIDENTIAL AND WILL BE USED FOR YOUR SOLE BENEFIT. TO INSURE YOUR PRIVACY, PLEASE DOWNLOAD, PRINT, THEN ENTER THE DATA IN YOUR OWN HANDWRITING

COMPRHENSIVE CONFIDENTIAL QUESTIONNAIRE

DATE _____ NAME _____ BIRTHDATE _____

PLACE OF BIRTH _____ WHERE WERE YOU RAISED _____

CURRENT ADDRESS _____

a.m. PHONE _____ p.m.PHONE _____ CELL _____ e mail _____

SSN _____ DRIVER'S LICENSE # _____ REFERRED BY _____

NAME, ADDRESS AND PHONE NUMBER OF SOMEONE YOU AUTHORIZE ME TO CALL IN CASE OF EMERGENCY:

YOUR MARITAL STATUS _____ SPOUSE'S NAME _____ YOUR CHILDREN'S AGES AND NAMES _____

OCCUPATION _____ HOW LONG HAVE YOU HAD THIS JOB? _____

EMPLOYER'S NAME, ADDRESS, PHONE _____

LIST CAREER OR WORK PROBLEMS _____

HOW WOULD YOUR EMPLOYER AND COLLEAGUES DESCRIBE YOU? _____

IF YOU COULD DO ANYTHING YOU WANTED, WHAT WOULD YOU DO? _____

HAVE YOU BEEN IN THE MILITARY _____

WHAT IS THE LONGEST TIME YOU HAVE HELD A JOB? _____ WHEN _____

PRESENT SALARY _____

CAN YOU MANAGE ON IT? _____ HAVE YOU BEEN IN DEBT? _____

HAVE YOU EVER DECLARED BANKRUPTCY _____ WHEN _____

NAME, ADDRESS, PHONE OF NEAREST RELATIVE

NAME, ADDRESS OF PERSON RESPONSIBLE FOR YOUR FEES _____

NAME, ADDRESS FOR INSURANCE CLAIMS _____

DESCRIBE YOUR PERSONALITY AND HOW YOU FEEL ABOUT YOURSELF _____

WHAT WOULD YOU LIKE TO ACCOMPLISH IN THERAPY _____

HAVE YOU CONSULTED A MENTAL HEALTH PROFESSIONAL _____ WHO _____

WHERE _____ WHEN _____

WHY _____

--HOW DID IT HELP _____

HIGHEST LEVEL OF SCHOOL COMPLETED _____

MARITAL HISTORY

HOW MANY MARRIAGES HAVE YOU HAD? _____ HOW MANY FOR YOUR SPOUSE _____

AT WHAT AGES FOR YOU _____ FOR YOUR SPOUSE _____

HOW LONG DID THEY LAST FOR YOU _____ FOR YOUR SPOUSE _____

HOW LONG DID YOU KNOW YOUR CURRENT SPOUSE/MATE BEFORE YOU MARRIED? _____

HOW ARE YOU SUITED TO EACH OTHER _____

HOW ARE YOU DIFFERENT _____

WHAT DO YOU LIKE ABOUT YOUR SPOUSE _____

WHAT DON'T YOU LIKE ABOUT YOUR SPOUSE _____

LIST YOUR CHILDREN'S NAMES AND AGES _____

CITE PROBLEMS _____

AGE OF SEXUAL EXPERIENCE _____ WITH WHOM _____

WHAT WERE YOUR FEELINGS ABOUT IT LATER
ON _____
LIST
SEXUAL CONCERNS _____

HOW MANY CHILDREN IN YOUR FAMILY OF ORIGIN _____ NAMES & AGES OF YOUR
SIBLINGS _____

TO WHICH SIB DO YOU FEEL
CLOSEST _____ FURTHEST _____

BRIEFLY DESCRIBE YOUR MOTHER, FATHER, SISTERS AND
BROTHERS _____

WHO, IF ANY, WAS THE FAMILY
SCAPEGOAT _____ WHY? _____

LIST PAST OR CURRENT PROBLEMS WITH PARENTS

DO YOU CONSIDER YOURSELF RELIGIOUS _____ WHAT FAITH _____

PHYSICAL HISTORY

DATE OF LAST PHYSICAL EXAM _____ REASON _____

RESULTS _____ LIST CHRONIC AILMENTS _____

HEIGHT _____ WEIGHT _____ ANY RECENT CHANGE IN WEIGHT _____

HAVE YOU EVER HAD A HEAD INJURY? _____ DESCRIBE _____

DID IT REQUIRE A HOSPITAL? _____ WHEN _____ DIAGNOSIS _____

LIST DISEASES YOU HAVE HAD AND DATES _____

LIST YOUR PRESCRIPTION AND OTC MEDICINES _____

AGE OF MENSTRUATION _____ MENOPAUSE _____

SURGERIES AND DATES _____

OF PREGNANCIES _____ ABORTIONS _____ EATING DISORDERS _____

LIST STREET DRUGS YOU TAKE OR HAVE USED IN THE PAST

HOW OFTEN _____ WHEN DID YOU START _____ DO YOU WANT TO STOP? _____

HOW OFTEN DO YOU DRINK ALOCHOL _____ HOW MUCH _____

DO YOU WANT TO STOP _____ HOW MANY CIGARETTES DO YOU SMOKE PER DAY _____

HOW MANY TIMES PER WEEK DO YOU HAVE THE FOLLOWING:

VEGETABLES _____ BREAD/CEREALS _____ MEAT _____ EGGS _____ FISH _____

FRUIT _____ CUPS OF WATER PER DAY _____ DAILY CAFFEINE BEVERAGES _____

DESCRIBE YOUR APPETITE FOR FOOD _____

LIST YOUR FAVORITE FOOD _____

PLEASE LIST AGE OF OCCURRENCE WHERE APPLICABLE

TEMPER OUTBURSTS _____ BEDWETTING _____ HOW HANDLED _____

FEELINGS OF INFERIORITY _____ FRUSTRATION _____ POLICE ARRESTS _____

WHY _____

FIGHTS _____ CUTTING YOURSELF _____

FINGERNAIL BITING _____ SLEEP WALKING _____

INSOMNIA _____ NIGHTMARES _____ DIZZINESS _____ HEADACHES _____

SEEING OR HEARING THINGS THAT AREN'T THERE _____

DEPRESSION _____ HOW WAS IT TREATED? _____

SUICIDAL THOUGHTS OR ACTIONS _____ DATES _____

HOW WAS IT TREATED _____

UNUSUAL FEARS _____ SHYNESS _____ MOODINESS _____

LONELINESS _____ MARITAL PROBLEMS _____

DESCRIBE CURRENT COMPLAINTS AND EFFORTS TO HELP

HAVE YOU HAD THIS BEFORE? _____ WHEN? _____ WHAT HAPPENED

LAST TIME _____

DESCRIBE ANYTHING UNUSUAL GOING ON IN YOUR LIFE
NOW _____

DESCRIBE ANY PAST EVENTS IN YOUR LIFE WHICH WERE UNUSUAL _____

HOW WOULD THOSE WHO KNOW YOU WELL DESCRIBE YOU _____

BEST FRIEND'S NAME _____ FOR HOW LONG _____

DO YOU PREFER TO BE ALONE OR WITH PEOPLE _____

LIST THE MOST IMPORTANT PEOPLE IN YOUR LIFE PAST AND PRESENT

NAME _____ RELATIONSHIP _____ AGE _____

NAME _____ RELATIONSHIP _____ AGE _____

NAME _____ RELATIONSHIP _____ AGE _____

WITH WHOM DO YOU LIVE _____ DESCRIBE YOUR HOME _____

_____ HOBBIES AND INTERESTS _____

WHAT WEAPONS DO YOU OWN _____ WHY _____

WHAT IS YOUR FAVORITE ACTIVITY? _____

ON THE BACK OF PAGE 1, USING A PENCIL, DRAW A PERSON

ON THE BACK OF PAGE 2, USING A PENCIL, DRAW A HOUSE

ON THE BACK OF PAGE 3, USING A PENCIL, DRAW A TREE

ON THE BACK OF PAGE 4, DESCRIBE YOUR EARLIEST MEMORY

ON THE BACK OF PAGE 5, DESCRIBE ANY RECURRENT DREAM

ON THIS PAGE, PLEASE LIST ANY INFORMATION YOU THINK MAY BE HELPFUL IN OUR WORK TOGETHER

PLEASE LIST ANY QUESTIONS YOU WOULD LIKE ME TO ANSWER.