Shoudt & Reilly Psychological Services, LLC.

6720 E. Perkiomen Avenue, Birdsboro, PA 19508

Telephone #: 610-404-1726

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Client Information Questionnaire

(All information is confidential)

Date: ______________________

Name:____ Date of Birth:________________

Emergency Contact:_____________________________ Phone #:___________________

Relationship:__________________________________

Marital Status: ____Single ____Married ____Engaged ____Divorced ____Widowed ____ ____Domestic Partnership _____Separated

Occupation:___________________________________ Education:____________________

Family Physician:______________________________ Date of last exam:___________

Who referred you to us:__________________________ Relationship:_______________

List people who live in patient's home

Name	Age/Date of Birth	Relationship	Occupation
________________	________________	________________	________________
________________	________________	________________	________________
________________	________________	________________	________________
________________	________________	________________	________________
________________	________________	________________	________________
________________	________________	________________	________________

What is (are) the reason(s) for seeking treatment?

____

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To help us understand better what concerns you may have, please circle any of the following problems which pertain to you:

Nervousness	Depression	Fears
Shyness	Sexual Problems	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self-Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Stomach Trouble
Bowel Troubles	Parenting	Grief
My thoughts		

Cultural/Spiritual Issues

Some managed care companies require that we ask the following questions regarding cultural/spiritual issues. You may choose to respond or not respond.

1. With what ethnic/cultural/racial group do you identify?______________________
2. What is your religious affiliation?______________________________________
3. What role does your religion/spirituality play in your life?

   _____ Positive _____ Negative _____ Neutral

4. Are there any Spiritual or cultural issues that you feel need to be taken into account in your treatment? _______Yes _______ No (If yes, please explain)

____

____

____

Treatment History

1. Have you ever received mental health or substance abuse treatment?

____ Inpatient ____Outpatient ____ None

Place/Provider:_____________________ Year(s):__________ Reason:______________

Place/Provider:_____________________ Year(s):__________ Reason:______________

Place/Provider:_____________________ Year(s):__________ Reason:______________

Place/Provider:_____________________ Year(s):__________ Reason:______________

Place/Provider:_____________________ Year(s):__________ Reason:______________

2. When were you last seen by a mental health professional? ______________ ___N/A

3. Are you currently taking medication for anxiety, depression, insomnia, etc.?
   ____ Yes ____ No

If Yes,

Drug	When	How Long	Effectiveness

4. Have you in the past taken medication for anxiety, depression, insomnia, etc.?
   ____ Yes ____ No

If Yes,

Drug	When	How Long	Effectiveness	Why Discontinued

5. Does anyone in your family have a history of mental illness, emotional difficulties, or substance abuse? _____ Yes _____ No

Describe: ____

____

____

Medical History

1. Please list your family doctor and any other physicians or therapists involved in your care.

____

____

____

2. Do you have any health problems? _____ Yes _____ No

List: ________________________ ____________________________

________________________________ ____________________________

________________________________ ____________________________

3. Have you had any major, non-psychiatric hospitalizations? ____ Yes ____ No

If Yes, Place Year Reason

____

____

____

____

4. Are you currently taking medication for a health problem.? ____ Yes ____ No

If Yes,

Drug When How Long Effectiveness

____

____

____

5. Do you have any drug allergies or sensitivities? _____ Yes _____ No

Please list:

<u>Drug</u> <u>Symptom</u>

____

____

____

6. Do you have any other allergies or sensitivities (e.g. environmental, food, dye, latex, etc.)? _____ Yes _____ No

Describe: ____

____

Do you have any family history of medical problems, including diabetes, heart disease, cancer, Alzheimer's, asthma, etc? _____ Yes _____ No

Describe: ____

____

____

Diet, Substance Use, Lifestyle Issues

1. Are you on a special diet? _____ Yes _____ No

   Describe: ____

2. Current caffeine consumption (Soda, Coffee, Tea, Iced Tea, Etc)? ____ Yes ____ No
   Amount: ____
3. Do you take Over the Counter medications, herbal preparations, dietary supplements, etc.? _____ Yes _____ No
   Type: ____

4. Do you drink alcohol? _____ Yes _____ No

Type: ________________ Amount: ____________________ Last use:___________

5. Have you ever had a problem with alcohol? _____ Yes _____ No

   Describe: ____

6. Do you use any illicit drugs, e.g. marijuana, cocaine, hallucinogens, etc.? __Yes __No

Type: ________________ Amount: ____________________ Last use:___________

7. Do you use tobacco in any form? _____ Yes _____ No

Describe: ____

8. Have you ever experienced unprotected sex, needle sharing, or blood transfusion?

_____ Yes _____ No Describe: _______________________________________

Other

Is there any other pertinent information it is important for your clinician to know?

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