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www.H.O.P.E.PsychotherapyOfHouston.com

New Patient Questionnaire/Psychosocial History
(To be completed by the Patient)

Please complete this form to the extent that you feel comfortable. If any questions are particularly difficult, painful, or not applicable, please feel free to leave them blank and/or discuss them with me during your session. If you need more space for any answers, please use margins or back of sheet.

Name: _____ **Date:** _____

Gender: ___F ___M Date of Birth: _____ **Age:** _____

Referred By: _____
(e.g., Name of physician, website, friend, yellow pages, etc.)

Primary reason(s) for seeking services: _____

Family Information

Relationship	Name	Age	Living? Yes	Living? No	Lives with you? Yes	Lives with you? No
Mother						
Father						
Spouse/Partner						
Children						

Significant others (e.g., siblings, grandparents, etc.) Please specify relationship.

Relationship	Name	Age	Living? Yes	Living? No	Lives with you? Yes	Lives with you? No

Current Marital Status: (please circle all that apply)

Single Married Living together Committed relationship
Divorced Widowed Engaged Separated

Length of current marriage/relationship: _

Number of marriages/serious relationships: _____

Assessment of current relationship (if applicable):

I feel safe in my current living situation: __Yes __No (please explain)

I feel safe in my current romantic relationship: __Yes __No (please explain)

Growing up, I was raised by/lived with:

My childhood was:

I usually get along with my parents: □Yes □No because:

I usually get along with my siblings: □Yes □No because:

Development

Are there any special, unusual, or traumatic circumstances that affected your development?

Type of discipline used in my home when growing up:

_____

_____

_____

Has there been a history of abuse in your past? __ Yes __ No

If yes, which type(s):
__Emotional/verbal abuse __Physical __ Sexual __Neglect/Abandonment

Comments:_____

_____

_____

_____

Social Relationships

I usually get along with other adults: □Yes □No because:_

_____

_____

_____

I usually get along with children: □Yes □No because:

_____

_____

_____

I have friends: □ No □ Yes #_____ _____Males _____#Females

Sexual orientation: _____ Comments: _____

Sexual problems or dysfunction: __ Yes __ No
If yes, describe: _____

Cultural/Ethnic

With which cultural, racial, or ethnic groups do you identify? _____

Are you experiencing any concerns related to cultural, racial, or ethnic issues? __No __Yes If yes, please describe: _____

_____

_____

Other pertinent cultural/racial/ethnic information:

_____

_____

_____

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17510 Huffmeister Rd., #102 & #103
Cypress, TX 77429
281-373-5200 (Ofc.)

Religious/Spiritual Affiliation:

_____

_____

_____

Would you like your spiritual/religious beliefs incorporated into therapy? __ Yes __No
If yes, please describe:

_____

_____

_____

Legal

I have been involved with the legal system: □No □Yes Describe:

_____

_____

_____

Education/Employment

Highest level of education completed (including school name and diploma/degree):

_____

_____

_____

Currently enrolled as a student? __No __ Yes

Current employer: □N/A_____

Job title/Occupation: □N/A_____

Career Concerns? _____

Military experience (i.e., branch, rank, type of discharge, combat experience, etc.): □N/A____

_____

_____

_____

Medical/Physical Health

I have the following medical problems:

_____

_____

_____

List all current medical issues and past accidents/surgeries/medical issues that may still affect you presently.

I take the following prescription or over the counter medications including vitamins/supplements/herbs:

Name of medicine **Reason**

Use additional space at bottom/back of this page if needed.

Please describe any recent changes in sleep, eating, behavior, weight, disposition, or energy level:

List any concerns you may have about your sleep and/or eating habits:

Chemical Use History

I have used the following types of alcohol/illegal substances: put a * by your drug of choice

Name of drug	Age of first use	Amount/Frequency	Date of last use

Are you or someone you love concerned about your use of alcohol or drugs?
__ Yes __No

Have you ever sought help (inpatient treatment or 12 step program) for substance abuse or addiction?
__ Yes __ No If yes, please describe:

Please list any family history of drug or alcohol abuse:

Counseling/Prior Treatment History

I have cut, burned, scratched, or hurt myself before: __No __Yes If yes, please explain:

I have attempted suicide before: __No __Yes If yes, please explain:_____

Are you currently suicidal? __ No __ Yes
If yes, please explain:

I have thought about killing someone else: __No __Yes because:_____

I have had previous treatment (e.g., inpatient, private therapist, residential treatment):
__No __Yes because:_____

If you have previously seen a therapist, what did you like or dislike about that experience_____

I am willing to receive therapy: □No because:_____**□Yes because:**_____

What are your expectations or goals for therapy? _____

Please list any other information that might be helpful in understanding you or assist in your therapy:_____

Patient or Legal Guardian Name:_____

Patient or Legal Guardian Signature:_____

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