



FAYETTEVILLE
PSYCHOTHERAPY
Associates, PLC

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Confidential Patient Questionnaire

This questionnaire is designed to gather important information about you and to assist your therapist in assessing your treatment needs so that he or she may provide you with the optimum level of mental health care. Please answer each question as completely as possible.

Client Name: _____ Date of Birth: _____

Street Address: _____ SSN: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Work Phone: _____ Cell Phone: _____
Okay to leave message? Y N Okay to leave message? Y N Okay to leave message? Y N

Employer/School: _____ Occupation: _____

Employer/School address: _____

If college student, permanent mailing address: _____

If you wish to use your insurance coverage, please complete the following:

Insurance Co. name: _____

How are you listed on the policy? (check one): Insured Spouse Child

If you are not the insured, please provide the following information about the policy holder:

Name: _____ Date of Birth: _____ Sex: Male Female

Address of policy holder (if different from above): _____

By whom or how were you referred?

Insurance Company Patient Physician _____ Therapist _____
 Phone book Internet Other _____

My current relationship status is:

Never been married Single Married Separated Divorced Widowed
 Significant relationship Dating Not in any significant relationship Partnered

Children (List all)

<u>Name</u>	<u>Gender</u>	<u>Age</u>	<u>Living at Home</u>	<u>By Previous Marriage</u>
_____	<input type="radio"/> M <input type="radio"/> F	_____	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
_____	<input type="radio"/> M <input type="radio"/> F	_____	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
_____	<input type="radio"/> M <input type="radio"/> F	_____	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

I have initiated therapy to address the following issue(s) (please check all that apply):

- | | | | |
|--|---|--|--------------------------------------|
| <input type="radio"/> Depression | <input type="radio"/> Anxiety | <input type="radio"/> Marital difficulties | <input type="radio"/> Stress |
| <input type="radio"/> Parenting issues | <input type="radio"/> Sexual issues | <input type="radio"/> Substance abuse | <input type="radio"/> Trauma |
| <input type="radio"/> Career/work issues | <input type="radio"/> Self-Esteem | <input type="radio"/> Eating Disorders | <input type="radio"/> Grief/Recovery |
| <input type="radio"/> Abuse | <input type="radio"/> Divorce | <input type="radio"/> Family conflict | <input type="radio"/> Gambling |
| <input type="radio"/> Excessive Exercise | <input type="radio"/> Relationship Issues | | |
| <input type="radio"/> Other _____ | | | |

I have a history of, or I am currently experiencing, the following medical conditions (check all that apply)

- | | | | |
|---|---|--|-----------------------------------|
| <input type="radio"/> Diabetes | <input type="radio"/> High blood pressure | <input type="radio"/> HIV/AIDS | <input type="radio"/> Cancer |
| <input type="radio"/> Sleeping disorders | <input type="radio"/> Heart Disease | <input type="radio"/> Eating disorders | <input type="radio"/> Allergies |
| <input type="radio"/> Migraines/Headaches | <input type="radio"/> Epilepsy | <input type="radio"/> ADHD | <input type="radio"/> Head Injury |
| <input type="radio"/> Low Blood Pressure/Fainting | <input type="radio"/> Thyroid | <input type="radio"/> Persistent medical condition | |
| <input type="radio"/> Other _____ | | | |

I have taken, or am currently taking, medication(s) to treat the following:

<i>Taking</i> Currently	<i>Past</i> Use		<i>Taking</i> Currently	<i>Past</i> Use		<i>Taking</i> Currently	<i>Past</i> Use	
<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	HIV/AIDS
<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	Sleeping disorders	<input type="radio"/>	<input type="radio"/>	Epilepsy
<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Allergies	<input type="radio"/>	<input type="radio"/>	ADHD
<input type="radio"/>	<input type="radio"/>	Heart Disease	<input type="radio"/>	<input type="radio"/>	Sexual Dysfunction	<input type="radio"/>	<input type="radio"/>	Anxiety
<input type="radio"/>	<input type="radio"/>	Other _____						

Please list all medications you are currently taking and how long you have taken them (please include any over the counter or herbal medicines you take regularly):

_____ taken since: _____	_____ taken since: _____
_____ taken since: _____	_____ taken since: _____
_____ taken since: _____	_____ taken since: _____

When was your last physical exam? _____

My current primary care physician is: _____ Phone: _____

My highest level of education completed is:

- GED HS Diploma College Degree Graduate Degree

I have had previous psychotherapy or mental health treatment consisting of (check all that apply, list most recent dates):

<u>Type of Therapy</u>	<u>Dates of therapy</u>	<u>With whom?</u>
<input type="radio"/> Individual outpatient psychotherapy	_____ to _____	_____
<input type="radio"/> Outpatient Intensive Treatment Program (IOP)	_____ to _____	_____

- Outpatient Partial Hospitalization Program (PHP) _____ to _____
- Inpatient treatment _____ to _____
- Marital/couples therapy _____ to _____
- Group therapy _____ to _____
- Family therapy _____ to _____
- Pastoral counseling _____ to _____

I have, or have had, difficulty falling asleep, staying asleep or sleeping too much:

- Never
- In the past, but not at present
- From time to time
- Within the last 6 months
- Within the last 4 weeks

I drink alcoholic beverages:

- Never
- I have in the past, but do not at present
- From time to time
- Several times a month
- Several times a week
- Daily

I use recreational drugs:

- Never
- I have in the past, but do not at present
- From time to time
- Several times a month
- Several times a week
- Daily

Are you worried about your appearance in any way?

- Rarely
- Daily
- So much that it is affecting happiness in my life
- Several times a month
- Several times a week

Please describe your concern: _____

How many times per week do you exercise?

- One or less
- Two to four
- Five or more
- More than once daily

I have difficulty concentrating on things:

- Never
- I have in the past, but do not at present
- From time to time
- Several times a month
- Several times a week
- Daily

I have thoughts of suicide or of hurting myself:

- Never
- I have in the past, but do not at present
- I currently have thoughts of suicide or harming myself
- I have serious thoughts of harming another person

I have thoughts of homicide or harming another person

- Never
- I have in the past, but do not at present
- I currently have thoughts of homicide or harming another person

If yes, describe who, when, how _____

I am now, or may be involved in the near future, in the following situations that may require testimony, participation, or release of records from my therapist:

- Divorce or Separation Disability or Worker's Compensation Criminal Proceedings
- Child Custody proceedings Child welfare proceedings Other _____

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) had a history of any of the following conditions? Please indicate which family member or members (such as Mother, Uncle, Grandfather etc.):

<u>Condition</u>		<u>Family Member(s)</u>
Depression	<input type="radio"/> Yes <input type="radio"/> No	_____
Anxiety Disorders	<input type="radio"/> Yes <input type="radio"/> No	_____
Bipolar Disorder	<input type="radio"/> Yes <input type="radio"/> No	_____
Panic Attacks	<input type="radio"/> Yes <input type="radio"/> No	_____
Schizophrenia	<input type="radio"/> Yes <input type="radio"/> No	_____
Suicide Attempts	<input type="radio"/> Yes <input type="radio"/> No	_____
Eating Disorders	<input type="radio"/> Yes <input type="radio"/> No	_____
Alcoholism	<input type="radio"/> Yes <input type="radio"/> No	_____
Drug Abuse	<input type="radio"/> Yes <input type="radio"/> No	_____
Obsessive Compulsive Disorder	<input type="radio"/> Yes <input type="radio"/> No	_____
Other _____		_____

What are your goals for therapy?

What are your strengths?
