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**Confidential Patient Questionnaire**

This questionnaire is designed to gather basic 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: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

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 \_\_\_\_\_  
 FayPsych.com     Internet     Other \_\_\_\_\_

My current marital status is:

- Never been married     Single     Married     Separated     Divorced     Widowed

How many times have you been married? \_\_\_\_\_

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
_____	<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"/> 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"/> Other _____         |   |  |                                   |

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

<u>Taking</u> <u>Currently</u>	<u>Past</u> <u>Use</u>		<u>Taking</u> <u>Currently</u>	<u>Past</u> <u>Use</u>		<u>Taking</u> <u>Currently</u>	<u>Past</u> <u>Use</u>	
<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

Please list all medications you are currently taking and how long you have taken them:

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

My current primary care physician is: \_\_\_\_\_

My current psychiatrist is: \_\_\_\_\_

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"/> Inpatient treatment	_____ to _____	_____
<input type="radio"/> Marital/couples therapy	_____ to _____	_____
<input type="radio"/> Family therapy	_____ to _____	_____
<input type="radio"/> 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

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
- From time to time
- I currently have thoughts of suicide or harming myself

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	_____
Other _____		_____

What are your goals for therapy?

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