Psychosocial Questionnaire

NAME: _____ DOB: _____ DATE: _____

Address: _____

Home Phone Number: _____ Work: _____ Cell: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Physician's Name: _____ Address: _____

Phone: _____ Fax: _____

Family Information

Relationship	Name	Sex	Age	Lives with you?	Conflict with?
Client					
Mother					
Father					
Spouse					
Children					
Siblings					
Others					

Marital Status

[] Single [] Married [] Divorced [] Separated [] Living with: _____

If divorced, when and from whom? _____

Assessment of current relationship: [] Good [] Fair [] Poor

Spiritual / Religious

Do you consider yourself a spiritual person? [] No [] Yes

What Religion were you raised? _____

Do you practice a formal religion now? [] No [] Yes

If so, what religion do you currently practice? _____

Have you ever participated in a retreat? [] No [] Yes

Have you received spiritual direction? [] No [] Yes

If yes, when? _____ With whom? _____

Education

[] High School Diploma

[] Currently Enrolled; Where: _____

[] College Grad [] Vocational Training

Employment

Beginning with your most recent job, give employment history including military.

Employer	Dates	Job Description

Medical History

Please note any prescribed medications:

Medication	Dosage	Who prescribed it	Reason

Do you currently take any over-the-counter medications? If so, please list.

_____

_____

Do you have concerns with any of the following areas?

[] Eating Problem
[] Allergies
[] Anemia
[] Asthma / Coughing
[] Severe Headaches
[] Cancer
[] Chest Pain
[] Chronic Pain
[] Diabetes
[] Sexual Problems
[] Stroke
[] Appetite / Eating
[] Excessive Bleeding
[] Fainting / Unconsciousness
[] Fatigue
[] Frequent Urination
[] STDs
[] Sleeping Problem
[] Hypertension
[] Kidney Problem
[] Neurological Problem
[] Thyroid Problem
[] Stomach / Digestive Problem
[] Epilepsy / Seizures

Do you have any past major physical conditions that have had an effect on you?

_____

Do you have any major physical conditions that are currently affecting you?

_____

Do you have any problems with alcohol or substance abuse? [] No [] Yes

If so, please explain: _____

_____

Prior Counseling/ Treatment History

Psychiatric/ Counseling: [] No [] Yes When: _____

Where: _____ Briefly describe_____

_____

Suicidal Thoughts: [] No [] Yes When: _____

Where: _____ Briefly describe_____

_____

Drug/ Alcohol Treatment: [] No [] Yes When: _____

Where: _____ Briefly describe_____

_____

AA/ NA/ Al-Anon/ Self Help: [] No [] Yes When: _____

Where: _____ Briefly describe _____

_____

Legal History

Do you currently have any legal problems? (Civil, criminal, traffic) [] No [] Yes

If so, please explain: _____

_____

Do you have any money problems? [] No [] Yes

If so, please explain: _____

Why You're Here

The reason I came to see Paul was: _____

_____

What I hope to accomplish is the following: _____

_____

What else would you like to tell Paul or think he should know about you?

_____

_____

Fee Agreement

In the event that I need to cancel an appointment, I agree to do so as soon as possible and no later than 24 HOURS IN ADVANCE of my scheduled appointment. If I fail to do so,

I agree to pay a $50 No Show or Late Cancellation Fee.

I am responsible for payment at the time services are rendered at the following rates:

$75 for a 50 minute session
$125 for a 90 minute session
$50 per individual for a 75 minute group therapy session

Consent to Treatment

My signature below indicates that I, or my child, voluntarily seek treatment with Paul Thompson, MS. I understand that:

- I have the right to discuss with Paul any issue, whether I am dissatisfied, confused or I feel that I am not making progress or wish to terminate treatment.
- The treatment setting is to be free of physical, sexual, and other abuse, threats and acts of violence. All persons in the setting will be expected to be free of the influence of alcohol and non-prescription drugs and follow the treatment recommendations.
- Therapy may be discontinued at any time by either party.

Client Notice of Confidentiality

The confidentiality of consumer records maintained by Paul Thompson, MS is protected by State and Federal law and regulations. Generally, the office may not disclose any information identifying a consumer as a recipient of mental health or alcohol/drug treatment services unless: (1) The consumer consents in writing; (2) The disclosure is allowed by a court order; (3) The disclosure is made to medical personnel in a medical emergency; or (4) There is suspected child abuse or neglect. Federal law does not protect information about a crime, or threat, committed at the office or against any person at the office.

My signature below indicates that I have read, understand, and agree to the above items.

_____ _____
Patient Signature Date

_____ _____
Paul Thompson Date