Pacific Sunrise Psychological Services
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HEALTH QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Ethnicity: _____

Referred By: _____ Reason for Referral: _____

PRESENTING PROBLEM:

Please describe your reason(s) for seeking treatment at this time. Please identify any significant events that contributed to your decision to seek treatment now.

_____

_____

_____

_____

_____

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	Not at all	A little	Some	Much	Significantly	
Relationship	0	1	2	3	4	N/A
Family	0	1	2	3	4	N/A
Job / School	0	1	2	3	4	N/A
Friendships	0	1	2	3	4	N/A
Finances	0	1	2	3	4	N/A
Physical Health	0	1	2	3	4	N/A
Anxiety	0	1	2	3	4	N/A
Depression	0	1	2	3	4	N/A
Eating	0	1	2	3	4	N/A
Sleep	0	1	2	3	4	N/A
Sex	0	1	2	3	4	N/A
Alcohol / Drugs	0	1	2	3	4	N/A
Concentration	0	1	2	3	4	N/A
Anger	0	1	2	3	4	N/A

GOALS FOR THERAPY:

How are you hoping treatment can help you? If you were doing "better", what would that look like?

_____

_____

_____

_____

_____

MEDICAL HISTORY:

Please check all that apply

MEDICAL CONDITION	Yes	No
Frequent headaches		
Insomnia		
Bruxism or TMD		
High blood pressure		
Diabetes		
Chronic pain		
Respiratory disorder		
Head injuries		
Nutrition concerns		
Hearing difficulty		
Vision problems		
Serious accidents		
Cancer		
Thyroid difficulties		

Are you currently in any physical pain today? **YES / NO**

If yes, LOCATION: _____

INTENSITY: **1 2 3 4 5 6 7 8 9 10**

Is your pain being treated? **YES / NO**

Current medications: (please include dose/frequency)_____

_____

_____

_____

Hospitalizations / Surgeries: (please include dates)_____

_____

_____

_____

MENTAL HEALTH HISTORY:

Have you ever received mental health treatment before? If so, please list dates, providers, and reasons for treatment:

_____

_____

_____

If you are being treated by a psychiatrist, please provide his/her name and contact information:

_____

_____

Have you ever received substance-related treatment before? (such as drug, alcohol, or other addictions) If so, please list dates, facilities, and description of addiction:

_____

_____

IMMEDIATE FAMILY HISTORY:

	YES	NO	If yes, please describe:
Medical Illness	☐	☐	_____
Mental Health Illness	☐	☐	_____
Substance Abuse	☐	☐	_____
Legal Issues (arrests/jail)	☐	☐	_____
History of suicide	☐	☐	_____

EMOTIONAL AND BEHAVIORAL FUNCTIONING:

HABITS:

	YES	NO	If yes, please list quantity/frequency:
Nicotine products	☐	☐	_____
Caffeine use	☐	☐	_____
Alcohol use	☐	☐	_____
Workout supplements	☐	☐	_____

HOBBIES: _____

STRENGTHS: _____

_____

_____

WEAKNESSES: _____

_____

_____

Average number of hours of **SLEEP** per night: **1 2 3 4 5 6 7 8 9 10+**

Average **STRESS** level: **0 1 2 3 4 5 6 7 8 9 10**

Is there anything else I need to know now to better help you?

_____

_____

_____

_____

_____

_____