Patient Information:

Patient's Birth Name: _____

Patient's Preferred Name:_____

Preferred Pronouns:_____

Patient's Date of Birth:_____

Patient's Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Patient's Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ On leave

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) -_____-_____ Cell Phone: (_____) -_____-_____

Work Phone: (_____) -_____-_____ Other Phone: (_____) -_____-_____

E-Mail Address: _____

How would you like to be notified? Check all that apply: ☐ Phone ☐ Text ☐ Email ☐ None

☐ *By checking this box, I give permission to QCC to send non-sensitive information through the means above*

Emergency Contact Information:_____

Name | Relationship to Client | Telephone Number

☐ *By checking this box, I give QCC permission to contact the abovenamed person in the case of an emergency*

How did you hear about us: _____

(Name) (Company)

Insurance Information:

Insurance Company: _____

Insured Person: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Insured's Street Address: _____

Insured's City: _____State: _____ Zip:_____

Insured's Phone: (_____) - _____- _____ Insured's Birth-Assigned Gender: ___

Insured's Date of Birth: _____/_____/_____

Insured's Employer: _____

Insured's ID # (from card): _____

Insured's Group # (from card): _____

Insurance Phone Number (back of card): (_____) - _____- _____

What brings you to therapy at this point?

_____

_____

Symptoms:

___Anxiety	___Depression	___Sleep problems	___Thoughts of suicide
___Panic	___Unusual thoughts	___Anger outbursts	___Changes in weight
___Crying spells	___Memory problems	___Sexual problems	___Relationship issues
___Treated unfairly	___Frequent pain	___Low energy	___Concentration issues
___Restlessness	___Nausea	___Eating disorder	___Legal problems
___Drug use	___Drinking problem	___Boredom	___Hopelessness
___Stress	___Shyness	___Work problems	___Confusion
___Guilt feelings	___Suspicion	___Loneliness	___Thoughts of hurting others
___Compulsions	___Worried	___Money problems	___Difficulty with decisions
___Specific fears	___Mourning	___Physical illness	___Poor motivation
___Feeling abandoned	___Meaninglessness	___Perfectionism	___Unusually sensitive
___Irritability	___Social withdrawal	___Feeling misunderstood	___Troublesome thoughts
___Religious concerns	___Disappointment	___Impulsive	___Hearing strange voices
___Feeling inferior	___Irrational thoughts	___Mood swings	___No problems or concerns

What 3 symptoms checked above are most bothersome to you?

Discuss any additional concerns or symptoms here:

_____

_____

What stresses or life changes have you experienced recently?

Have you seen a therapist in the past?

YEAR	PROBLEM	THERAPIST OR CLINIC	HOW LONG

What have you liked and disliked about past therapy/treatment?

Your family (as you experienced them growing up):

RELATIONSHIP	FIRST NAME	PERSONALITY/MENTAL HEALTH ISSUES

What are these relationships like today?

About your childhood: Please indicate if these issues impacted you (C); your father (F); your mother (M); a sibling (S); or another family member in the home (O). Write in all that apply:

___Happy childhood	___Neglected(A)	___Emotionally abused	___Moved frequently
___Physically abused	___Few friends	___Incarcerated, Jailed(A)	___Sexually abused(A)
___Weight problems	___Popular	___Mental illness(A)	___Parents divorced(A)
___Family fights(A)	___Poor grades	___Suicide attempt(A)	___Conflict with teachers
___Drug or alcohol use(A)	___Good grades	___Premature death	___Sexual problems
___Depressed	___'Spoiled'	___Threats of violence(A)	___Anxious
___Not allowed to grow up	___Attention problems	___Humiliation	___Anger problems

Who lives with you now?:

RELATIONSHIP	FIRST NAME	PERSONALITY/MENTAL HEALTH ISSUES

How would you describe the current household?

_____

_____

_____

Relationship history:

How many times have you been married? ☐ Name(s) of Partner(s): _____

How old were you at the time of your marriages? ☐

What are typical problems experienced in past or current marriages or romantic relationships?

Home Life:

How do you spend personal time? What hobbies, sports, clubs, groups, family activities, etc. are important to you?

How many contacts do you have each month with friends outside of work or school?

Who make up the important social relationships in your life--past or current?

Who can you talk with about personal feelings or private matters?

Are you satisfied with your romantic life?

What do you like and dislike about your current relationships—romantic and friendship

Education & Occupation:

Are you currently (check as many as apply)…….. ☐ Working ☐ In School ☐ Retired ☐ On Leave

Highest level of education so far? _____

What was your major or favorite subject? _____

How many hours per week are you working? _____

In what field do you usually work? _____

What is your current or most recent job title? _____

Briefly describe your likes and dislikes of work/school:

_____

_____

_____

Do you have any current or prior legal issues? Do you have any involvement with probation civil or criminal courts or any arrests or charges?

_____

_____

_____

Spirituality & Culture:

How does your spirituality, religion or belief system inform your life choices? What cultural groups do you identify with? How do you celebrate culture in your life?

_____

_____

_____

Health:

Primary Physician's Name: _____

Check each accident or illness you have experienced:

___Recent surgery	___Drug/alcohol abuse treatment	___Diabetes
___Head injury	___Neurological disorder	___Hormone problems
___Seizures	___Chronic pain	___Infertility
___Thyroid problems	___Headaches	___Miscarriages

List any other chronic health problems you may have:

How many hours do you sleep on average?

How many drinks containing alcohol do you consume in an average week?

Do you use (*nonprescribed*) drugs? What and how much during the past year?

What *prescription* medications, vitamins or supplements do you take?

Name of Drug	Dosage	For What Purpose?	Started
Name of Drug	Dosage	For What Purpose?	Started
Name of Drug	Dosage	For What Purpose?	Started

(Add additional to back page if necessary)

Do you exercise? What type and how frequently?

What, if anything, concerns you about your physical health?

What are your personal strengths? What areas are you most proud of? What skills and abilities do you bring to therapy?

What didn't I ask that I should know about you?