

**Behavioral Innovations, LLC**  
551 N Cherokee Rd  
Social Circle, GA 30025  
Ph: 770-825-8124 Fax: 770-825-9066

PATIENT NAME: \_\_\_\_\_

PATIENT DOB: \_\_\_\_\_ Marital Status: S M D W

STREET ADDRESS: \_\_\_\_\_

CITY/ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

PLEASE CIRCLE: This number is my: HOME / WORK / CELL number.

Is this the best number to reach you at? YES / NO

Can messages be left at this number? YES / NO

May we contact you at your work number? YES / NO

My work number is: \_\_\_\_\_

INSURANCE: \_\_\_\_\_

INSURANCE ADDRESS: \_\_\_\_\_

INSURANCE PHONE #: \_\_\_\_\_

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**What three things would you like to change by participating in counseling?**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**What do you think it might require on your part to make these changes?** You could mention how you tried to make changes in the past, specific medications that may have helped or not helped, or ways you have tried to overcome some of your issues on your own or with the help of a psychotherapist:

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**How long do you think it will take to make these changes?** \_\_\_\_\_

**What do you see as some of your strengths?** If you are not sure what they might be, think of some positive things that other people have noticed about you.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**How do you think you will know when you have accomplished your goals for counseling?**

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**What else do you think is important for your counselor to know about you?** \_\_\_\_\_

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**Emergency Contact:**

Who do you want contacted in case of an emergency? (Include name, phone number and relationship.)

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## Initial Questionnaire

Client name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

What is the reason for your appointment today?

How many psychotherapists/counselors have you seen in past for this problem and related problems?

What has been your past experience in psychotherapy/counseling so far?

Have you even been diagnosed with a mental illness?  Yes /  No

Are you presently in psychotherapy/ counseling with anyone?  Yes /  No  
If Yes, Who?

Any previous psychological testing? \_\_\_\_\_ Do you have reports? \_\_\_\_\_

Have you been hospitalized for psychiatric problems?  Yes /  No. If yes, how many times? \_\_\_\_ . When was the last time? \_\_\_\_\_

What is your opinion of psychiatric medications?

How many psychiatrists have you seen previously for medication management? \_\_\_\_\_

What has been your experience with medication so for? \_\_\_\_\_

Have you attempted suicide in the past?  Yes /  No

Do you physically hurt yourself?  Yes /  No

Do you have thoughts of seriously harming yourself or others now?  Yes /  No

Your education level: \_\_\_\_\_

Symptoms:	YES	NO
Have you been down, depressed, or hopeless in the past month?		
Are you bothered by little interest or pleasure in doing things?		
Has your appetite changed (eating more or less)?		
Has your sleep been disturbed (insomnia or over-sleeping)?		
Do you feel worthless or guilty?		
Do you have sudden or unexpected bouts of anxiety or nervousness?		
Do you often feel tense, worried, or stressed?		
Do you have acute onset of symptoms such as palpitations, shortness of breath, or trembling?		
Do you worry about a lot of different things?		
Do you avoid places or situations because of anxiety or worry?		
Do you have recurrent, persistent or unwanted thoughts or do repetitive behaviors?		
Have you been through any significantly stressful periods on the past 6 months?		
In your lifetime, have you faced any potentially life-threatening events such as natural disaster, serious accident, physical or sexual assault/abuse, military combat or child abuse?		
Since you experienced any of these stressors, have you been easily startled?		
Angry or irritable?		
Emotionally numb or detached from your feelings?		
Prone to physical reactions when reminded of the event?		
Do you use prescription medicines or street drugs to relax, calm your nerves, or get high?		
Have you made an effort to cut down on your drinking or drug use?		
Have you been annoyed by people who criticize your drinking or drug use?		
Do you ever feel guilty about your drinking or drug use?		
Do you ever drink or use drugs to steady your nerves, get rid of a hangover, or relieve withdrawal symptoms?		

Your occupation / work: \_\_\_\_\_

Did you have a happy childhood?  Yes /  No

Where you raised by your parents?  Yes /  No

How was your relationship with your parents growing up?

How is your relationship with your parents now?

Were you abused or molested as a child?  Yes /  No

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

Who do you presently live with?

How many children do you have? \_\_\_\_\_

What are the major problems in your present household?

Who is supportive of you at this time?

Are you facing any legal difficulties at this time?  Yes /  No

How much difficulty are you having presently in functioning at your work/ home life/school?

What religious and spiritual values are important to you?

What are some of your strengths and abilities?

What are some of your needs?

Do you have any specific preferences for your care?  
If yes, please describe:

Substance Use history:

Substance	Age at First Use	Date/Age at Last Use	Duration & Frequency of Use
Alcohol			
Marijuana			
Methamphetamines			
Amphetamines			
Cocaine			
Benzodiazepines			
Barbiturates			
Hallucinogens			
Opiates (Prescription)			
Methadone			
Heroin			
PCP (Angel Dust)			
Inhalants			
Prescription Drugs			
Other illicit Substances			
Caffeine			
Tobacco (smoking/chewing)			

Have you ever had treatment for substance-abuse?  Yes /  No

Do you have any medication allergies?  Yes /  No; If yes, describe:

Environmental/food allergies?  Yes /  No; If yes, describe:

Family history of psychiatric illness:

Problem/Illness	In Which Family Member
Nervous breakdown	
Depression	
Bipolar disorder	
Anxiety/panic	
Drug abuse	
Alcohol abuse	
Suicide with a gun	
Suicide (other)	
Violent crime	
Survivor of abuse	
Abuser or Molester	

Circle all problems present now or in past:

Allergies	Asthma	Chronic cough/bronchitis	Snoring
Chest pain	Heart problems	Palpitations	Mitral valve prolapse
Swelling of feet	High blood pressure	Thrombosis	On blood thinners
Problem with urination	Miscarriages	Sexual problems	Sexually Transmitted Diseases
Abortions	HIV	Weight gain	Weight loss
Diarrhea	Constipation	Liver problems	Heartburn/indigestion
Stroke	Headaches	ringing in ears	Hearing aids
Vision problems	Thyroid problems	Infections	TB
Genetic Problems	Diabetes mellitus	High sensitivity to medications	Seizures
Nausea and vomiting	Arthritis/muscle pains	Numbness or tingling	Other problems:

Family history of physical illness:

Problem/Illness	In Which Family Member
Diabetes	
Heart disease	
Sudden-death	
Other major illness	

Who is your Primary Care Physician? \_\_\_\_\_

Other doctors seemed regularly: \_\_\_\_\_

**IMPORTANT:** Current non-psychiatric medications and dosages: \_\_\_\_\_

\_\_\_\_\_