SANDSTONE PSYCHOLOGICAL PRACTICE

Christina L. Aranda, Ph.D. & Janell M. Mihelic, Ph.D.

New Client Questionnaire

CONTACT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____

_____

Preferred Phone Number: _____ Type: Home Cell Work Other

Is it okay to leave messages?: YES NO

Is it okay to text appointment reminders?: YES NO

Email: _____

Is it okay to send email?: YES NO

DEMOGRAPHIC INFORMATION (Please answer to the extent you are comfortable.)

Ethnicity: _____ Place of Birth: _____

Sexual Orientation: _____ Gender: _____

Highest level of education completed (8th grade, MS degree, etc.) _____

What is your current occupation? _____

Are you a parent? YES NO

Are you currently in the branch of the military? YES NO

Are you a veteran? YES NO

Are you a college student? YES NO

Do you currently have a diagnosed disability? YES NO

2501 North Green Valley Parkway, Suite 130D, Henderson, NV 89014
Phone: 702.405.0904 Fax: 702.405.0924
Email: ContactUs@SandstonePsych.com
www.SandstonePsych.com

INSURANCE [Do not complete if you have provided a copy of your insurance card.]

Health Insurance Carrier: _____ Insurance Policy No: _____

Insurance Phone: _____ Group No: _____

Insurance Address: _____ Cardholder Name: _____
***Please provide if different from client.**

_____ Cardholder DOB: _____
***Please provide if different from client.**

Card Holder's Address: _____

_____

PRESENTING CONCERN(S)

Referred by: _____

Primary reason(s) you are seeking services:

_____

_____

_____

_____

Are you experiencing any of the following? Check all that apply.

____ Sadness or Depression
____ Panic Attacks
____ Obsessive Thinking
____ Sexual Issues
____ Grief and/or Recent Loss
____ Recent Sexual Assault
____ Self Harm Behaviors (w/o Suicidal Intent)
____ Sleep Problems
____ Academic Problems
____ Problems Making or Keeping Friends
____ Substance Abuse
____ General Anxiety
____ Specific Fears/Phobias _____
____ Relationship Concerns
____ Disordered Eating and/or Body Image Concerns
____ History of Abuse (emotional, physical, sexual)
____ Family Problems
____ Loss of Energy
____ Problems with Attention or Concentration
____ Test Anxiety
____ Anger Problems
____ Alcohol Problems

Other Symptoms Not Listed Above: _____

_____

Are you currently experiencing suicidal thoughts? YES NO

Have you ever purposefully injured yourself **without** suicidal intent? YES NO

Have you ever made a suicide attempt? YES NO

If yes, when?: _____

Are you currently having thoughts about harming someone? YES NO

Have you ever intentionally physically harmed someone? YES NO

If yes, when?: _____

CURRENT/ PAST MENTAL HEALTH TREATMENT

Are you currently in counseling or therapy elsewhere?: YES NO
If yes, please list the name and number of your current service provider: _____

_____

Have you had counseling/ psychotherapy in the past? YES NO
If yes, please include the provider, approx. dates, and any diagnoses: _____

_____

Are you **currently** taking prescribed **psychiatric** medications? YES NO
If yes, please specify which medication(s): _____

_____

Have you taken **psychiatric** medicine in the **past**? YES NO
If yes, which medication and when?: _____

_____

Have you ever been psychiatrically hospitalized? YES NO
If yes, when, where, and for what? _____

_____

Have you ever been tested for ADHD or Learning Disabilities? YES NO
If yes, please include the provider, approx. dates, and any diagnoses: _____

_____

FAMILY INFORMATION

Relationship status (check which applies):

____ Single
____ Living with partner
____ Married/partnered
____ Separated
____ Divorced
____ Widowed
____ Other

Who currently resides in your home (Name, relationship, age)?:

_____

_____

_____

_____

Has anyone in your family had any of the following psychological disorders? Check all that apply and list who (Mother, Father, Sibling, Aunt, Child ... etc).

____ Mental Retardation/Intellectual Disability: _____
____ Speech or Communication Disorder: _____
____ Attention-Deficit Hyperactivity Disorder: _____
____ Learning Problems/Disability: _____
____ Autism Spectrum/Asperger's Disorder: _____
____ Sleep Disorders: _____
____ Anxiety: _____
____ Obsessive-compulsive disorder: _____
____ Phobias: _____
____ Depression: _____
____ Bipolar Disorder: _____
____ Suicide Attempts/Completed Suicide: _____
____ Schizophrenia or Other Psychosis: _____
____ Alcohol Abuse: _____
____ Drug/ Substance Abuse: _____
____ Seizures or Other Neurological Disorders: _____
____ Genetic Disorder (e.g., Down Syndrome, Fragile X): _____
____ Other: _____

GENERAL HEALTH

Are you currently receiving care for a medical condition(s)? YES NO
If yes, what condition and name your provider: _____

_____

Rate your present physical health: Poor Fair Good Excellent

When was your last physical exam? _____

List any medications (and dosages) you take regularly. Include prescriptions, over the counter pills, vitamins, and supplements:

_____

_____

_____

Do you exercise? YES NO

If yes, # times/ frequency: _____

Do you drink caffeinated beverages? YES NO

If yes, # drinks/frequency: _____

Do you smoke cigarettes? YES NO

If yes, # cigarettes/frequency: _____

Do you drink alcohol? YES NO

If yes, # drinks/frequency: _____

Do you use drugs/ substances? YES NO

If yes, specify which, # times/ frequency: _____

Do you consider your alcohol use to be a problem? YES NO NOT SURE

Do you consider your substance use to be a problem? YES NO NOT SURE

Please use this space below to share with us anything else that you would like us to know?

_____

_____

_____

_____

_____

_____

_____

_____

2501 North Green Valley Parkway, Suite 130D, Henderson, NV 89014
Phone: 702.405.0904 Fax: 702.405.0924
Email: ContactUs@SandstonePsych.com
www.SandstonePsych.com