

SANDSTONE PSYCHOLOGICAL PRACTICE

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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

1070 West Horizon Ridge Parkway, Suite 210, Henderson, NV, 89012

Phone: 702.405.0904 Fax: 702.405.0924

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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.

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

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

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

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:

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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?
