Personal Details

The information required in this questionnaire will help us to plan and provide you with high quality care. Please answer each question carefully. If you do not understand a question, leave it blank and ask the psychologist about it at your first appointment.

Name: ____ Today's Date: _______________________

Address: ____ Phone: (home) _____________________

____ (work) _____________________

____ (Mobile) _____________________

(E-Mail) _____________________

May we leave messages for you? At home? Yes No On Mobile? Yes No
At work? Yes No On E-Mail? Yes No

Age: _____ Birth Date: _____/_____/_____

Occupation: ________________________________ Employer: _______________________________________

Relationship Status: Single _____
Living w/partner _____
Married _____
Divorced _____
Widowed _____

Time in current relationship: ___________

Length(s)/date(s) of previous relationships: _______________

____

Spouse/Partner's Name: ____ Age: ____________

Occupation: ____ Employer: _________________________________

Contact in Case of Emergency: ____

Please list all members of your family and any other people currently living in your home:

Name(s) Age Relationship Occupation

____

____

____

____

____

____

Please list all members in your family or origin:

Name(s)	Age	Relationship	Occupation

Who is your GP?____ GP Practice: __________________________________

Please list others currently providing health or mental health care: ____

____

Please list any health problems for which you are currently receiving treatment or have received treatment in the past:

____

____

Please list any prescription or non-prescription drugs you are now taking: ____

____

Have you ever received psychiatric or psychological help of any kind before? _____ If so, please explain when where, with whom, and for what reason(s): ____

____

____

Briefly describe your reasons for seeking help now: ____

____

____

Please add any additional information that you might consider useful: ____

____

Please circle all of the following issues or problems that currently pertain to you:

Stress
Relaxation
Nervousness
Anxiety
Fears
Chest Pains
Muscle Tension
Headaches
Dizziness
Nervous Tics
Palpitations
Excessive Sweating
Excessive Thirst
Phobic Avoidance
Compulsions
Rituals
Health Problems
Stomach or Bowel
Troubles
Physical Pain
Menstrual Problems
Hearing Problems
Visual Disturbance
Eating Pattern
Weight
Binging
Anger
Withdrawal
Vomiting
Purging
Unhappiness

Self-Worth
Tiredness
Boredom
Memory
Concentration
Guilt
Making Decisions
Over-Focused
Inferiority Feelings
Suicidal Thoughts
Suicidal Plans
Suicidal Behaviour
Purpose in Life
Fitting In
Friends
Loneliness
Relationships
Shyness
Physical Contact
Shame
Abuse
Flashbacks
Dissociation
Nightmares
Hurting Self
Risk-Taking Behaviour
Loss of Interests
Temper Outbursts
Attention Deficit
Thrill-Seeking
Appetite

Loss of Control
Suspicious of Others
Marriage
Divorce
Parenting
Parents
Separation from Partner
Sexual Problems
Gender Issues
Education
Learning Disability
Finances
Career Choices
Work
Ambition
Avoidance
Legal Matters
My Thoughts
My Beliefs
Feeling Disconnected
Odd Behaviour
Seeing Things
Hearing Things
Delusions
Unusual Experiences
Sleep Problems
Aggressive Behaviour
Drug/Alcohol Misuse
Self-Control
Depression
Jealous Feelings