PSYCHOTHERAPY ASSOCIATES OF THE PALM BEACHES, INC.

BONNIE GOLDMAN MS, LMHC / PSYCHOTHERAPIST

Name:_____DOB:_____Date:_____

BIOGRAPHICAL QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions as fully and as accurately as you can, we'll be able to offer you as soon as possible the treatment most in line with your reasons for coming to this Clinic. If you do not want to answer a question, merely write "Do not care to answer."

PRESENTING PROBLEMS & CONCERNS

Please describe the primary problem/concern for which you have come to our clinic:

What led to your decision to seek help right at this time?

On the scale below please circle the description that best estimates the overall impact on you of your problem(s):

Mildly Upsetting Moderately Upsetting Very Severe Extremely Severe

When did your problems begin? (give dates)

Please describe any significant events occurring at that time, or since then, which may relate to the problem(s):

What has been the impact of your problem on your daily routine, your life, and/or others?

What solutions to your problems have been most helpful?

Have you been in therapy before or received professional assistance for your problems? Yes No

If so, when and was it helpful?

Dates Location Was it helpful?

Have you ever been hospitalized for mental or emotional problems? Yes No
If yes, when and how many times?

Dates Location Was it helpful?

Have you ever had thoughts of hurting yourself or committing suicide? Yes No
If yes, please explain:

Have you ever attempted suicide? Yes No

If yes, when? How? _____

Do you have thoughts of suicide now or have you within the past month? Yes No

Has any relative attempted or committed suicide? Yes No

Does any member of your family suffer from alcoholism, depression or anything else that might be considered a "mental disorder?"

☐ Family member Problem How long ago?

EDUCATIONAL HISTORY

How many years of education have you completed? _____

What degrees do you have? _____

Check any of the following that applied during your educational experience:

- ☐ Held Back a Grade
- ☐ Skipped a Grade
- ☐ Suspended
- ☐ Physical Fights in School
- ☐ Special Education
- ☐ English Second Language
- ☐ Difficulty Reading
- ☐ Difficulty Writing
- ☐ Belong to a Gang
- ☐ Attention Problems
- ☐ Concentration Problems
- ☐ Other:_____

PERSONAL & SOCIAL HISTORY

Check any of the following that applied during your childhood and adolescence:

- ☐ Happy Childhood
- ☐ Legal Trouble
- ☐ Medical Problems
- ☐ Unhappy Childhood
- ☐ Parents Divorced
- ☐ Physical Abuse
- ☐ Emotional Problems
- ☐ Family Problems
- ☐ Sexual Abuse
- ☐ Behavioral Problems
- ☐ Drug or Alcohol Abuse
- ☐ Other: _____

Do you engage in unprotected sex? Yes No

If married, what strengths do you see in your marriage?

If married, what problems do you see in your marriage?

Is your present sex life satisfactory? Yes No

If not, please explain:

WORK AND HOME ACTIVITY STATUS

How many jobs have you held? _____ _

Have you ever been fired from a job? Yes No

Check any that are currently on-the-job issues:

- Trouble with Boss
- Conflict with Peers
- Concentration Problems
- Memory Problems
- Trouble with Customers
- Disciplinary Action
- Trouble with Subordinates
- Job loss

Please explain any checked items above:

How well do you believe you are keeping up with your responsibilities on the job? (circle choice)

1 Extremely Poor 2 3 4 5 Extremely Well

How satisfied are you with your current occupation? (circle choice)

1 Extremely unsatisfied 2 3 4 5 Extremely Satisfied

How well do you believe you are keeping up with your responsibilities at home? (circle choice)

1 Extremely Poor 2 3 4 5 Extremely Well

How satisfied are you with your current family life? (circle choice)

1	2	3	4	5
Extremely Unsatisfied				Extremely Satisfied

How satisfied are you with the support you receive from your family/friends? (circle one)

1	2	3	4	5
Extremely Unsatisfied				Extremely Satisfied

BEHAVIOR &.FEELINGS

Check any of the following behaviors that apply to you recently:

- ☐ Overeating
- ☐ Vomiting
- ☐ Loss of Control
- ☐ Sleep Disturbances
- ☐ Impulsive
- ☐ Suicide Attempts
- ☐ Smoke
- ☐ Drink Too Much
- ☐ Aggressive
- ☐ Temper Outbursts
- ☐ Can't Keep a Job
- ☐ Odd Behavior
- ☐ Eating Problems
- ☐ Procrastinate
- ☐ Crying
- ☐ Take Drugs
- ☐ Withdrawal
- ☐ Work Too Hard
- ☐ Compulsions
- ☐ Phobic Avoidance
- ☐ Concentration Problems
- ☐ Take Too Many Risks
- ☐ Other_____
- ☐_____

Check any of the following feelings that <u>often</u> apply to you recently and that you find <u>troublesome</u>:

- ☐ Angry
- ☐ Contented
- ☐ Guilty
- ☐ Hopeless
- ☐ Jealous
- ☐ Lonely
- ☐ Annoyed
- ☐ Fearful
- ☐ Excited
- ☐ Hopeful
- ☐ Unhappy
- ☐ Sad
- ☐ Panicky
- ☐ Happy
- ☐ Optimistic
- ☐ Bored
- ☐ Depressed
- ☐ Energetic
- ☐ Conflicted
- ☐ Helpless
- ☐ Tense
- ☐ Anxious
- ☐ Envy
- ☐ Regretful
- ☐ Relaxed
- ☐ Restless

PHYSICAL FACTORS

Check any of the following that often apply to you recently and that you find <u>troublesome</u>:

- ☐ Headaches
- ☐ Tension
- ☐ Unable to Relax
- ☐ Fainting
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Visual Problems
- ☐ Fatigue
- ☐ Hear Things
- ☐ Blackouts
- ☐ Palpitations
- ☐ Numbness
- ☐ Back Pain
- ☐ Skin Problems
- ☐ Sweating
- ☐ Muscle Spasms
- ☐ Tics/Twitches
- ☐ Tremors
- ☐ Dry Mouth
- ☐ Bowel Problems
- ☐ Stomach Trouble
- ☐ Sexual Problems
- ☐ Hearing Problems
- ☐ Rapid Heart Beat

Do you have any current concerns about your physical health and/or chronic health problems? Yes No

If yes, please describe:

Please list any medicines you are currently taking or have taken during the past 6 months (including aspirin, birth control pills, or any medicines that were prescribed).

Have you lost or gained or lost weight in the last few months without planning to do so? Yes No

If yes, how much? (gained or lost)

What caused the loss or gain?

Do you get regular physical exercise? Yes No
If so, what type and how often?

Do you practice relaxation or meditation regularly? Yes No

ADDITIONAL INFORMATION

Thank you for the effort and time you have already expended in completing this questionnaire. We hope this effort will also help you in better defining and focusing in on the changes you want to make. Please tell us in the space below anything else you would like us to know about you or your background that would help us work you toward your better health.

TREATMENT GOALS

In order to help you identify the treatment options most in line with your needs, we are asking you to complete the following list of possible treatment goals. Each set of treatment goals leads to particular recommendations for treatment; these will be discussed with you during your individual assessment interview. Please read each item then mark the three which ***three*** goals you <u>most</u> wish to discuss/change at this time.

- ☐ Reducing fear
- ☐ Reducing worry
- ☐ Improving communication with _____
- ☐ Improving sexual relationship
- ☐ Reducing family difficulties

- ☐ Learning how I come across to others
- ☐ Not taking disappointment so hard
- ☐ Doubting myself less
- ☐ Feeling more comfortable relating to others

- ☐ Expressing myself more assertively
- ☐ Reducing my sensitivity to possible criticism
- ☐ Learning problem-solving/decision-making techniques
- ☐ Not reacting so emotionally
- ☐ Feeling more self-confident

Being better at identifying my needs and wants

- ☐ Learning how to relax
- ☐ Improving sleep
- ☐ Reducing muscle tension

- ☐ Feeling less guilt
- ☐ Feeling less depressed
- ☐ Thinking more positively
- ☐ Controlling eating/weight
- ☐ Learning to decrease stress
- ☐ Dealing with abuse issues
- ☐ Learning to cope with chronic pain
- ☐ Being better at identifying my need

How motivated are you to work on the goals you selected above? Very Somewhat A little

What strengths or resources do you have that will help you work on the goals you have selected?

_____

_____

_____

_____

_____

What barriers or problems may prevent you from making progress on the goals you have selected?

_____

_____

_____

_____

_____

_____

Welcome!

REGISTRATION FORM

Section I: Patient Information **Date**_____

Name:_____ I Prefer to be called: _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____
Email Address_____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____