Country Counseling, LLC

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Loveland, CO 80537

CONFIDENTIAL QUESTIONNAIRE

Today's Date: _____

Name:_____

Date of Birth: _____ Age:_____

Primary Phone Number: _____Type: ☐ Cell ☐ Home ☐ Business
Permission to leave a message? ☐ Yes ☐ No

Alternate Phone Number: _____Type: ☐ Cell ☐ Home ☐ Business
Permission to leave a message? ☐ Yes ☐ No

Address: _____
Street City State Zip
Permission to mail confidential materials (including statements) to this address? ☐Yes ☐No

Email address:_____ Permission to use email? ☐Yes ☐No
Please note that email will only be used for non-clinical correspondence, such as scheduling sessions, and should not be used to communicate sensitive information. The security of email cannot be guaranteed and the confidentiality of your protected health information cannot be fully ensured if you chose this method of correspondence. Selecting "Yes" indicates that you understand and accept all risks to confidentiality.

Emergency Contact

At certain times, it is important for me to contact a trusted person to ensure your safety or others' safety. I will describe this in detail at our first appointment and answer any questions you may have.

Name: _____ Relationship: _____

Primary Phone Number: _____Type: ☐ Cell ☐ Home ☐ Business

Alternate Phone Number: _____Type: ☐ Cell ☐ Home ☐ Business

Address: _____
Street City, State Zip

Please answer the following questions as fully as you feel comfortable.
We will review this information in more detail during our first meeting.

Demographics
(Please check all that apply)

Gender: ☐ Male ☐ Female ☐ Transgender MTF ☐ Transgender FTM ☐ Intersex

Relationship Status: ☐ Single ☐ Married/Partnered ☐ Separated ☐ Divorced ☐ Widowed
☐ Other: _____

Sexual Orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bi-Sexual ☐ Questioning
☐ Other: _____

Ethnicity/Race: ☐ Caucasian ☐ African-American ☐ Asian ☐ Pacific Islander
☐ Native American ☐ Alaskan Native ☐ Chicano ☐ Latino ☐ Hispanic
☐ Arab American ☐ Other:_____

Spiritual/Religious Affiliation: ☐ Yes: *(please specify)*_____ ☐ No
Level of importance to you: ☐ Very high ☐ Moderate ☐ Low ☐ Questioning
Would you like to incorporate spirituality into your work in therapy? ☐ Yes ☐ No

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Education and Work

Highest degree/educational attainment:_____

Currently in School? ☐ Yes ☐ No
If yes, School Name:_____Major:_____
Class: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate ☐ Other:_____
School Status: ☐ Full Time ☐ Part Time

Any difficulties with school or changes in performance? ☐ Yes ☐ No
If yes, please describe:

Employer: _____ ☐ Full Time ☐ Part Time ☐ Not Employed

Any difficulties with work or changes in performance? ☐ Yes ☐ No
If yes, please describe:

Living Arrangements

Do you live? ☐ Alone ☐ With Roommates ☐ With Family of Origin ☐ With Spouse/Partner
☐ Other:_____

Are you satisfied with your living arrangement? ☐ Yes ☐ No
If no, please describe:

How did you hear about Country Counseling, LLC?

☐ Family Member or Friend ☐ Facebook ☐ Website ☐ Psychology Today Listing
☐ Google or Bing Search ☐ Health Care Professional: *(name)*_____
☐ Other: *(source)*_____

Current Health Care Providers

Primary Care Physician:_____ Phone:_____

Psychiatrist: _____ Phone:_____

Dietician: _____ Phone:_____

Other: _____ Phone:_____

Current Concerns

Please briefly describe what has been troubling you:

When did you start having a problem with this?

How have you tried to cope with this so far? What was most successful?

What strengths do you have that will help you to overcome what is bothering you?

What is your main goal from therapy?

Please check the concerns you are currently experiencing:

☐ Depressed mood	☐ Panic attacks	☐ Increased energy	☐ Restricting food
☐ Difficulty concentrating	☐ Extreme worry	☐ Obsessions	☐ Binge eating
☐ Lack of pleasure	☐ Muscle tension	☐ Compulsions	☐ Purging
☐ Worthlessness	☐ Fearfulness	☐ Self-injury	☐ Impulsiveness
☐ Sleep disruption	☐ Flashbacks	☐ Relationship problems	☐ Memory problems
☐ Changes in appetite	☐ Hypervigilance	☐ Hallucinations	☐ Substance abuse
☐ Excessive guilt	☐ Racing thoughts	☐ Delusions	☐ Low self-esteem
☐ Hopelessness	☐ Rapid speech	☐ Sexual concerns	☐ Family problems
☐ Mood swings	☐ Irritability or anger	☐ Negative body image	☐ Paranoia
☐ Intrusive thoughts	☐ Nightmares	☐ Social concerns	☐ Phobias

Suicidal and Assaultive Thoughts

Do you **currently** think about suicide or hurting yourself (burning, cutting, etc.)? ☐ Yes ☐ No
If yes, please describe:

Do you **currently** intentionally hurt yourself? ☐ Yes ☐ No
If yes, please describe

Have you **ever** had thoughts about suicide or hurting yourself in the past? ☐ Yes ☐ No
If yes, please describe:

Have you **ever** intentionally hurt yourself or attempted suicide? ☐ Yes ☐ No
If yes, please describe:

Do you **currently** think about hurting someone else or a specific group of people? ☐ Yes ☐ No
If yes, please describe:

Have you **ever** thought about hurting someone else or a specific group of people? ☐ Yes ☐ No
If yes, please describe:

Have you **ever** been physically violent towards, hurt, or threatened to hurt someone else? ☐ Yes ☐ No
If yes, please describe:

Mental Health History

Have you ever been formally diagnosed with a mental health concern? ☐ Yes ☐ No
If yes, please list the diagnosis, date of diagnosis, and who diagnosed you:

Have you ever been hospitalized for mental health reasons? ☐ Yes ☐ No
If yes, please list dates of hospitalization, where hospitalized, duration of hospitalization, and reason

Have you been in therapy before? ☐ Yes ☐ No
If yes, please list approximate dates, provider's name, concerns addressed, and reason discontinued

Substance Use

Please describe your use of:

	Current Use		Past Use	
	Number of days per week	Amount per day	Number of days per week	Amount per day
Alcohol				
Illicit Drugs				
Prescription Drugs *(not used as prescribed)*				
Tobacco				
Other				

Do you believe you currently have a difficulty with substance abuse? ☐ Yes ☐ No

If yes, please describe?

Medications

Please list all current medications, including those for mental health AND medical diagnoses:

Medication	Dose	Prescribed by

Please list past medications prescribed for mental health reasons:

Medication	Dose	Reason Discontinued

Medical History

Have you ever experienced?

☐ Head injury ☐ Seizure ☐ Loss of consciousness ☐ Severe Illness ☐ Hospitalization

Please describe:

Please list any current medical conditions, who diagnosed you, and what you are doing for treatment:

Legal History

Are you being court-ordered for treatment? ☐ Yes ☐ No
If yes, please describe:

Please list any prior convictions or pending charges:

Family History and Social Support

Do you have a history of mental health concerns or substance abuse in your family? ☐ Yes ☐ No
If yes, please list relationship (e.g., father, sister, etc.) and concern:

Please describe your relationships with your family members:
Mother:_____
Step-Mother:_____
Father:_____
Step-Father:_____
Siblings:_____
Grandparents:_____
Children:_____
Other:_____

Please describe your support systems (friendships, coworkers, religious groups, etc.) and how close you feel towards them:

Trauma History

Have you been in an incident where you or another person was physically harmed or killed? ☐ Yes ☐ No
If yes, please describe:

Have you witnessed an incident where someone was physically harmed or killed? ☐ Yes ☐ No
If yes, please describe:

Have you ever been physically or sexually abused? ☐ Yes ☐ No
If yes, please describe:

Have you ever been raped or sexually assaulted? ☐ Yes ☐ No
If yes, please describe:

Additional Concerns

Have there been any other major life changes in the past year?

☐ Relocation ☐ Divorce/Separation ☐ Graduated ☐ Change in employment
☐ Retired ☐ Family death ☐ Changes in friends ☐ Illness in family or friends
☐ Other: _____

Please describe:

Is there anything else that would be important for me to know?

Thank you for taking the time to complete this questionnaire.
Your answers will be useful for helping me to understand your concerns.