Gwen Shelton, LCSW
Patient Questionnaire

Name_____SS#_____

Address_____
Street City State Zip

Phone: Home_____Cell_____Work_____

Age_____ Birthdate _____Marital Status _____Gender _____

Years of school completed _____ Highest Degree _____Major _____

May we contact you at home? _____ Work? _____ Email _____

Would you like to receive a reminder text or phone call? If so, which do you prefer? _____

Who referred you?_____

Medical

Name of physician _____Date of last exam_____

Major health problems_____

Medications_____

Surgeries/when?_____

Insurance

_____

Policy holder's name Employer Policy holder's birthdate

_____

Insurance Company Policy holder's SS# Policy Number

Responsible Party (if other than client)_____

Address_____

Emergency Contact_____ Phone number_____

ASSIGNMENTS OF BENEFITS: I request that payment of private insurance for my treatment be made to Gwen Shelton, LCSW.
***Signature of patient or his/her representative_____**

CONSENT TO TREATMENT: I consent that I, or the person whom I represent, receive psychological treatment from Gwen Shelton, LCSW
***Signature of patient or his/her representative_____Date_____**

Reason(s) for seeking psychological help:_____

_____

Previous psychological or psychiatric treatment_____

Hospitalizations with dates_____

What is causing you stress?_____

Check any of the following that apply to you:

____Sleeplessness	____Isolating	____Anxiety	____Too much energy
____Sleeping too much	____Depression	____Panic Attacks	____Temper Outbursts
____Crying	____Feeling worthless	____Problem thoughts	____Aggressive behavior
____Sadness	____Feeling hopeless	____Compulsions	____Impulsive reactions
____Grief	____Death wishes	____Obsessions	____Take too many risks
____Too little energy	____Suicidal thoughts	____Appetite problems	____Can't keep a job
____Low motivation	____Worrying	____Eating problems	____Drink too much alcohol
____Memory problems	____Nervousness	____Relationship	____Illegal drugs
____Concentration problems	____Fears	____Sexual problems	____Other_____

Check any of the following that often apply to you:

____Angry	____Fearful	____Happy	____Hopeful	____Bored	____Optimistic
____Annoyed	____Panicked	____Conflicted	____Helpless	____Restless	____Tense
____Sad	____Energetic	____Shameful	____Relaxed	____Lonely	____Shy
____Envious	____Regretful	____Jealous	____Contented	____Anxious	____Unassertive
____Guilty	____Hopeless	____Unhappy	____Excited	____Other feelings_____	

Describe any mood problems you have_____

_____

Women: Do your menstrual periods affect your mood?_____ Date of last period_____

Do you ever think about killing yourself? No____ Yes____ If yes, describe_____

Have you ever attempted suicide? No____ Yes____ If yes, describe_____

Have you ever deliberately hurt yourself? Explain_____

Have you ever seen or heard things that were not there?_____

Have you ever thought that others were trying to harm you? Explain_____

_____

Are you bothered by thoughts that occur over and over again? No____ Yes_____

Do you have trouble relaxing or enjoying weekends and vacations? No____ Yes____ If yes,

explain_____

Have you ever had any eating disorder problems? No____ Yes____ If yes, describe_____

_____

Do you drink alcohol? No____ Yes____ How much/often?_____

Do you have a history of substance abuse? No___ Yes___ If yes, please describe and list any SA treatment you have received_____

FAMILY HISTORY

Where were you born and raised? _____

Was there anything unusual about your early development? _____

Father's age_____ Occupation_____Health_____If deceased give his age at time of death_____ Cause of death _____Your age at the time_____

Mother's age_____ Occupation_____Health_____If deceased give her age at time of death _____ Cause of death _____Your age at the time_____

Siblings: Names and ages of brothers and/or sisters: _____

_____

Give significant details about siblings and describe how you get along with them _____

_____

Were you brought up by your parents? _____ If not, who raised you? _____

Describe your relationship with each parent _____

_____ How good was your childhood? _____

If your parents divorced how old were you? _____ remarry? _____ How old were you? _____

Describe your relationship with your stepparents _____

Is there any history of substance abuse or psychiatric problems in your family history? If yes, please describe _____

Has anyone inside or outside your home abused you physically _____Verbally_____ Sexually____?

FAMILY

Are you married? _____ years of marriage _____Spouse's age _____ Spouse's occupation_____

How satisfied are you with your marriage? Very Dissatisfied 1 2 3 4 5 6 7 8 9 10 Very Satisfied

Are you divorced? _____When? _____ Years of marriage _____

Are you widowed? _____Cause of spouse's death_____ When_____ Years of marriage ____

Number of previous marriages and any significant details _____

Names and ages of children _____

Please describe any special problems presented by your children _____

_____

OTHER

How long have you worked at your current job? _____ How satisfied are you with your work?_____

List jobs you have held in the past _____

Describe any problems in your work relationships _____

Do you exercise regularly? _____ If yes, what type and how often? _____

Have you ever smoked? _____ If yes, when did you start? _____When did you last smoke?_____

Have you ever been in a fight? _____ How often do you get in fights? _____

Date of last fight _____

If you have had any legal problems, describe what and when _____

_____

How do you spend your free time? _____

_____

Do you make friends easily? No _____ Yes _____ Do you wish you had more friends? _____

How do you calm yourself when stressed? _____

List the persons available to you when you need social support _____

_____

Do you have an active faith life? _____ If you attend church where and how often?

_____

Strengths that will help you in therapy? _____

Possible challenges to therapy? _____

Additional relevant information _____

_____

_____