Wendy Mosqueda, M.A., MFT
Licensed Marriage and Family Therapist

PATIENT QUESTIONNAIRE

DISCLAIMER: The purpose of this Patient Questionnaire is to help me help me understand your background more and get to know you, so I can better support you in your treatment. Please be aware that some of the questions below can be of sensitive nature and difficult to answer. Should any of these be uncomfortable or upsetting to you, please feel free to leave it blank so we can discuss in person instead. Thank you!

Section 1: General

Name: _____DOB:_____
Gender: _____ Marital Status:_____ Primary Language:_____
Ethnic background (optional):_____Cultural background?_____
Living Arrangements (including number of people in the home):
_____

Religious Affiliation:_____ Actively involved?_____

Section 2: Areas of Concerns

What issues/areas of concerns lead you to seek treatment? Please describe.

Do you have specific goals/things you would like to see different as a result of being in treatment?

Do you have any concerns with regard to being in treatment?

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Section 3: Symptoms

Out of the seven days of the week, how many times have you experienced any of the following in the last 30 days:

Joy: ____:7	Loss of energy:____:7	Insomnia:____:7
Sadness____:7	Too much energy:____:7	Hypersomnia:____:7
Anxiety/Nervousness____:7	Low motivation:____:7	Naps:____:7
Irritability:____:7	Changes in Appetite:____:7	-for how long?____
Overflowing joy:____:7	Forgetfulness:____:7	
Other:_____		

Have you ever experienced hearing sounds or voices that others denied hearing?

Have you ever experienced seeing things that others denied seeing?

Have you experienced suicidal thoughts in the last 30 days?

Section 4: Treatment History

Have you ever been in treatment? If so, what was your experience like?

What was the reason for seeking services then? For how long were you in treatment?

Have you even been hospitalized for a psychiatric condition? If so, when and where? What lead up to the hospitalization?

Have you ever experienced suicidal thoughts? If so, when was the last time you experienced these thoughts?

Have you ever attempted suicide? (dates, means).

Have you ever been a victim of a crime? Do you consider you have been abused in the past (physically, emotionally, mentally, financially, sexually, bullied, other?

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Section 5: Medical History

How is your health? Do you have any medical conditions?

Are you currently on medication? If so, please provide name and prescribing physician.

Name of Primary Care Physician, phone number:

Section 6: For Children and Youth

To be filled out by parents/legal guardian.
Do you have any concerns with your child's development, and/or, has the school ever mentioned any concerns?

Does your child have an IEP? If so, what is the category for which your child receives extra support?

This for was completed by:

_____ _____

Print Date

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