PDJ PSYCHOTHERAPY & CONSULTING, INC.
A Professional Corporation
Patricia D. Johnson, Psy.D.
Licensed Marriage & Family Therapist
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PATIENT QUESTIONNAIRE/INTAKE

General:

Name ____ Date __________________________
(Please Print)

Name ____ Home phone ___________________
(Please Print)

Name ____
(Please Print)

Address ____ Cell phone ____________________

City/Sate/Zip Code ___________________________________ Other phone ___________________

Referred By ____

1. Patient's Date of Birth ___/___/____
2. Patient's Date of Birth ___/___/____
3. Patient's Date of Birth ___/___/____

Status (Check One) ____ Single ____ Married ____ Separated ____ Divorced _____ Widower/Widow

____ Other (Please explain ______________________________________)

Educational Level (Check One)

____ High School Graduate (or Equivalent) ____ Some College ____ College Graduate ____ Post Graduate
____ Other

Employer ____

Occupation ____

Names and ages of Children ____

Emergency Contact Information ____
Please Print Name of Emergency Contact, Address, and Phone Number(s)

Explanation of how patient may be contacted by therapist _________________________

Financial Information:

How do you intend to pay for treatment? (cash, check, credit card) _____________

Areas of Concern:

What issues/concerns causes you to seek treatment? Please describe. ________________

Do you have any specific goals with regard to your treatment? ______________________

Psychological History:

Have you ever received mental health treatment before? __________________________

When and for how long? ____

What was the focus of treatment? ____

Name of treating therapist(s), address(es), telephone number(s) ____________________

Authorization for release of confidential information will be needed so that any former therapist may be contacted.

Have you ever been hospitalized for mental or emotional problems? _________________

When and for how long? ____

Why were you hospitalized? ____

Name of treating therapist, address, telephone number ____________________________
Authorization for release of confidential information will be needed so that any former therapists may be contacted.

Are you currently taking any prescription medications? ___________________________

Prescribed by whom? ____

How long have you been on the medications? ___________________________________

Have you ever taken any medications for a mental or emotional condition? ___________

When and for how long? ____
Authorization for release of confidential information will be needed so that health care provider may be contacted.

Have you ever attempted suicide? ____

Have you ever become physically violent? _____________________________________

Medical History:

Have you or any family member ever been diagnosed with a serious illness? Please describe
____

Do you have any medical conditions that may affect your mental health treatment? _____

Please describe your overall health today. ______________________________________

Do you smoke? _____ How much? ____________ For how long? _______________

Do you drink alcohol? _____________

On average, how much alcohol do you consume in a week? _________________________

Other:

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. _________________________________

____

____

____

______________________________ (Signature)

__________________ (Date)

______________________________ (Signature)

__________________ (Date)

______________________________ (Signature)

__________________ (Date)

______________________________ (Signature)

__________________ (Date)