MIRACLE Counseling

PATIENT'S QUESTIONNAIRE

Date | Staff Member | Therapist Assigned

CALLER'S INFORMATION

REFERRAL FOR MINOR

☐ Mother ☐ Father ☐ Legal Guardian

☐ Foster Home ☐ Other (specify):

Caller's Name:

Phone: Email:

Comments:

REFERRAL FOR ADULT

☐ Mother ☐ Father ☐ Legal Guardian

☐ Assisted Living Home ☐ Other (specify):

Caller's Name:

Phone: Email:

Comments:

PATIENT'S PERSONAL INFORMATION

Name: DOB: Sex – ☐ F ☐ M ☐ Other

Home #: Cell #: Work #: Email:

Address: Apt #: City: State: Zip:

PRESENT SITUATION– Are you?

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Do you have Children – How many?

WORK SITUATION– Are you?

☐ Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Military ☐ Disabled ☐ Retired

DID SOMEONE REFER YOU TO OUR CLINIC?– IF SO SPECIFY

Clinic Name: Specific Provider:

☐ Received Letter ☐ Website ☐ Social Worker ☐ Friend ☐ United Way ☐ School ☐ Relative

☐ Received Postcard ☐ Physician ☐ Court System ☐ EAP ☐ Newspaper ☐ Internet ☐ Work

☐ Lawyer– Layer's Name? ☐ Other (specify):

WHY SEEK OUT THERAPY?

☐ Letter ☐ Immigration Letter ☐ Foster Situation ☐ Psychological Evaluation ☐ Personal Issue

☐ DV ☐ Disorderly Conduct ☐ Mandated by Court ☐ Anger Management

☐ Other (specify):

WHAT IS THE REASON FOR YOU SEEKING AN APPOINTMENT?

Explain:

MIRACLE Counseling

Have you previously suffered from this complaint? – ☐ YES ☐ NO	Start Date:
Previous therapist (s) for complaint – (if any):	Date Treated:

Previous mental health treatment/diagnose (s) – (if any):

Previous Medication (s) – (if any):

CURRENT SYMPTOMS (CHECK ALL THAT APPLY)

☐ Anxiety	☐ Sleep Changes	☐ Panic Attacks	☐ Racing Thoughts
☐ Depression	☐ Appetite Issues	☐ Suspiciousness	☐ Irritability
☐ Guilt	☐ Hallucinations	☐ Crying Spells	☐ Risky Activity
☐ Impulsivity	☐ Avoidance	☐ Excessive Energy	☐ Low Self-esteem

☐ Other (specify):

ARE THERE ANY SPECIFIC MENTAL HEALTH SERVICES YOU ARE INTERESTED IN?

☐ Nothing specific	☐ Other (specify):

TYPE OF THERAPY SEEKING

☐ Individual	☐ Couple	☐ Family	☐ Child	☐ Group	☐ Other (specify)

THERAPIST LANGUAGE PREFERENCE	☐ English	☐ Spanish	☐ Bilingual

Anything else you want the doctor to know?