MARK RUTHERFORD, LCSW
LICENSED CLINICAL PSYCHOTHERAPIST

HISTORY QUESTIONNAIRE

Name: _____

Date of Birth: _____ City of Birth:_____

Please describe the nature of the problem that brought you to seek counseling and how long this has been an issue for you.

Whom have you previously consulted about your present problem?

Check any of the following that apply to you:

__ Headaches
__ Palpitations
__ Bowel disturbances
__ Nightmares
__ Tension
__ Depression
__ Unable to relax
__ Don't like weekends
__ Can't keep a job
__ Weight loss/Gain
__ Easily Distracted
__ Fainting spells
__ Stomach troubles
__ Fatigue
__ Feel panicky
__ Suicidal thoughts
__ Sexual difficulties
__ Inferiority feelings
__ Memory problems
__ Poor home conditions
__ Dizziness
__ Residence change
__ No appetite
__ Sleep problems
__ Alcoholism
__ Tremors
__ Drug Use
__ Shyness
__ Can't make decisions
__ Can't make friends
__ Financial problems
__ Job Change
__ Concentration difficulties

_____ _____
(signature) (date)

MARK RUTHERFORD, LCSW
LICENSED CLINICAL PSYCHOTHERAPIST

HISTORY QUESTIONNAIRE

Please describe your family members:

NAME	AGE	GRADE/OCCUPATION	RELATIONSHIP	LIVES WITH YOU (yes/no)

Has anyone on your family suffered from alcohol/drug abuse, depression and/or anxiety?

Has anyone on your family suffered from mental illness?

What is the nature of your business?

Who is your current employer: _____

_____ (signature)

_____ (date)

MARK RUTHERFORD, LCSW
LICENSED CLINICAL PSYCHOTHERAPIST

HISTORY QUESTIONNAIRE

Please describe your drug and alcohol use:

How many of the following alcoholic beverages do you drink on the average:

	Daily	Weekly
Glasses of Wine	_____	_____
Cans or bottles of beer	_____	_____
Shots of hard liquor	_____	_____

Has anyone ever suggested you have a drinking problem?	YES	NO
Have you ever considered cutting down on your drinking?	YES	NO
Has your drinking or drug use ever been called to your attention?	YES	NO
Have you ever been charged with DUI or DWI?	YES	NO
Have you taken drugs?	YES	NO
Prescription: tranquilizers, amphetamines, steroids, etc…?	YES	NO
Non-Prescription: Marijuana, Cocaine, etc…?	YES	NO
Have you ever attended a support group?	YES	NO
Alcoholics Anonymous	YES	NO
Al-Anon	YES	NO
Overeaters Anonymous	YES	NO
Sex/Love Addicts Anonymous	YES	NO
Other	YES	NO
Do you smoke?	YES	NO
Do you want to stop?	YES	NO

_____ _____

(signature) (date)

MARK RUTHERFORD, LCSW
LICENSED CLINICAL PSYCHOTHERAPIST

HISTORY QUESTIONNAIRE

Have you ever had or do you now have any of the following:

__ Hepatitis	__ Anemia	__ Headaches
__ Diabetes	__ Stomach troubles	__ High blood pressure
__ Night Sweats	__ Pneumonia	__ Weight loss/gain
__ Tuberculosis	__ Asthma	__ Allergies
__ Skin Problems	__ Arthritis	__ Convulsions
__ Accident Prone	__ Venereal Disease	__ Kidney Trouble
__ Sexual Problems	__ Cancer	__ Surgery
__ Blackouts	__ Withdrawal	__ Gynecological Problems

What other symptoms or problems have you had that are not on this list?

_____

Are you taking any medications? YES NO

Please list them:

_____

Have you ever felt you were having a nervous breakdown? YES NO

Have you ever had psychiatric treatment/counseling? YES NO

When? _____ Where? _____

Please describe: _____

Have you ever been hospitalized for mental or emotional issues? YES NO

When? _____ Where? _____

Please describe: _____

Have you ever attempted suicide?

When? _____ Where? _____

Please describe: _____

Have you ever had a drug overdose?

When? _____ Where? _____

Please describe: _____

_____ _____

(signature) (date)