PSYCHOLOGICAL & BEHAVIORAL CONSULTANTS

INTENSIVE OUTPATIENT QUESTIONNAIRE

Please complete and bring to your first assessment session.

Name_____DOB_____Date_____

Reason for seeking treatment at this time:_____

Referral Source:

Name_____
May we contact? Yes____ No_____

Address_____

_____

Phone_____Fax_____

Primary Care Physician:

Name:_____
May we contact? Yes_____ No_____

Address:_____

_____

Phone_____Fax_____

Psychiatrist:

Name_____
May we contact? Yes____ No_____

Address_____

_____

Phone_____Fax_____

Psychologist, Therapist or Counselor:

Name_____
May we contact? Yes_____ No_____

Address:_____

_____

Phone_____Fax_____

Current medications (psychiatric and non-psychiatric) medication(s) and dosage:

_____

Religious, spiritual and cultural orientation and possible impact on treatment:_____

_____

Community resources/support (AA, NA, church, etc.):_____

_____

Family history of psychiatric and or alcohol/chemical dependency problems: relative and symptoms or diagnosis_____

_____

Please describe your strengths and assets:_____

Please describe any perceived weakness or limitations:_____