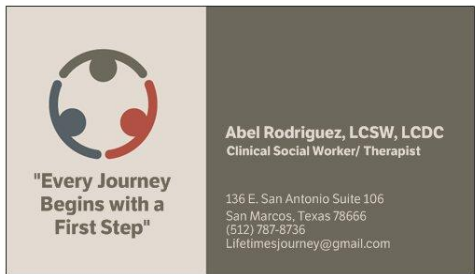


Questionnaire for Family

****The purpose of this form is to gain a perspective of patient through the view of a family member or friend****

Personal and Family Information

Name of Person (filling out form) ____

Relationship to Patient ____

Date of birth ____

Religion ____

Name of the Patient: ____

Describe Relationship to the Patient:

____

____

____

____

Please list people living in the home.

Name	Age	Relationship to Client

Relationship to Patient ________________________

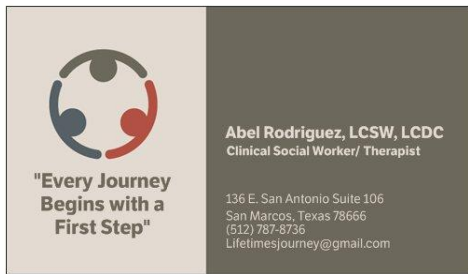
Please list other immediate family members not living in the client's home:

Name	Age	Relationship to Client
____________________	________________	________________________
____________________	________________	________________________
____________________	________________	________________________
____________________	________________	________________________
____________________	________________	________________________

Health Information

Date of last physical exam ____

Physician Name and Number ____



Please list any illnesses/medical conditions and date of diagnosis:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please list all medications and state purpose for each:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please list allergies (include allergies to medicine)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Do you any knowledge of the patient's history of abuse, sexually or physically, neglected, the victim of a crime, or otherwise traumatized? Yes No
If so, please describe

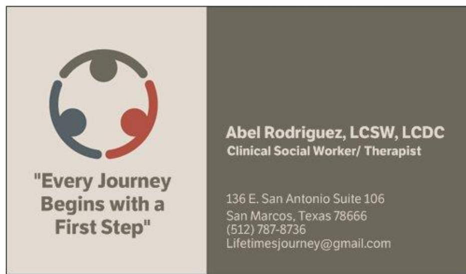
____
____
____

Please list the patient's hobbies and interests:

____
____
____

How would you describe the patient's relationship with peers?

____
____
____



Presenting Problem

Please state the reason you think the patient is seeking therapy:

____
____
____

To your knowledge, is the patient using or have used (Drugs) : YES NO
Describe:____
____
____

Has any other member of the family had a drug or alcohol problem, now or in the past?
Yes No

If so, please indicate who, the substance used, and whether the problem is ongoing:

____
____
____

Has any member of the patient's immediate family or extended family ever had mental disorder? Yes No
If so, please state the person's relationship to the client and the nature of the problem

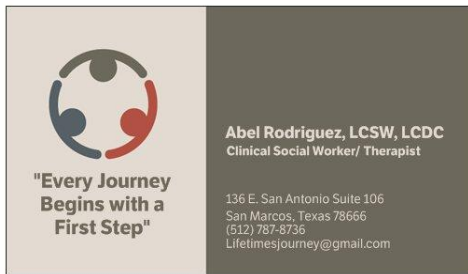
____
____
____

Has the patient ever received therapy before or had an evaluation? Yes No
If so, please name the provider and give dates

____
____
____

Please check any of the symptoms the patient is experiencing:

______Tiredness
______Sleep difficulties
______Sleep too much
______ Irritability
______ Worry
______ Crying
______ Confusion
______Lonely
______Withdrawal
______Loss of appetite
______Overeating
______ Anxiety
______Panic attacks
______Thoughts of suicide



______Suicide attempt
______Too passive

______Too aggressive
______Conflicts with others
______Excessive anger
______Excessive sadness

______ Decreased sexual desire
______Trouble concentrating
______Loss of interest in activities
______Thoughts of Better of dead
______Other__________________

When Did These Symptoms begin:_________________________________

____ ___________________________

(Print) (Signature) (Relationship) (Date)