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Psychosocial Questionnaire

Please fill out all questions below by yourself to the best of your ability. If you have any questions or do not understand something, please ask and I will explain it to you. Please answer every question, if it does not apply, please place (N/A) in the spot.

Name: _____

Address: _____

Telephone No.: _____ (H) _____ (W) _____ (C)

Age: _____ Birth date: _____ Sex: _____ SSN: _____

Drivers License No.: _____ Occupation: _____

Employer: _____

Employer Address: _____

Spouse Name: _____

Spouse Employer: _____

Health Insurance: _____

Insurance Address: _____

Insurance Phone No.: _____ Policy No.: _____

Insurance Group No.: _____

General Physician: _____
Name Phone No.

Address: _____

Describe Your History with Food Issues:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What Types of Diets have been on, list names and whether or not you had success with them:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Lowest Weight: _____ Highest Weight: _____

Age you starting having weight issues: _____ Current Weight: _____

Family Members Weight Issues:_____
_____

Previous Weight Loss Surgeries (Name and Dates): _____
_____
_____

Previous Eating Disorders (Dates):

Anorexia: _____ Bulimia: _____

Please describe any previous eating disorder behaviors (i.e., purging, laxatives, diuretics, diet pills, over exercise, etc.):

_____

_____

Previous Medical Surgeries (Name and Dates):

1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever had a head injury or loss of consciousness, if so, please describe? _____

_____

_____

Describe current eating issues, patterns of overeating. Please describe times you overeat, what you overeat on, struggles you are having with food.:

_____

_____

_____

_____

State your "bad" foods:

_____

_____

What are your reasons for wanting to lose weight:

1. _____
2. _____
3. _____
4. _____
5. _____

What gets in your way of losing weight:

1. _____
2. _____
3. _____
4. _____
5. _____

What reasons do you say to yourself to be okay to overeat?:

1. _____
2. _____
3. _____
4. _____
5. _____

What are the costs to you of overeating?:

1. _____
2. _____
3. _____
4. _____
5. _____

What are the benefits to you of overeating?:

1. _____
2. _____
3. _____
4. _____
5. _____

Please describe your exercise program (currently):

_____
_____
_____

Past exercise programs:

_____
_____
_____

What things do you to distract yourself from food?:

_____
_____
_____

How do you handle your stress?:

_____
_____

Hobbies: _____
_____

What are your strengths:

1. _____
2. _____
3. _____
4. _____
5. _____

What are your weaknesses:

1. _____
2. _____
3. _____
4. _____
5. _____

List social support system (who they are and how often you see them):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

CURRENT HISTORY

Do you smoke (how many per day)? _____ Do you drink alcohol? _____

If you drink alcohol, (how much and how often)? _____

Do you use drugs (what type, how often and how much)? _____
_____

PAST HISTORY

Smoking (how many per day)? _____ Alcohol? _____

Use of caffeine, (how much and when)? _____

Past alcohol use, (how much and how often)? _____

Previous drug use (what type, how often and how much)? _____
_____

Do you feel you have ever had a problem with drugs or alcohol, if so, please explain in detail:
_____
_____
_____
_____

Do you have suicidal thoughts (current or past), if so, please describe in detail?
_____
_____
_____

Have you ever attempted suicide, if so, please describe what happened and the dates?

1. _____
2. _____
3. _____

Have you ever been a victim of physical abuse, if so, when and for how long? _____
_____
_____

Have you ever been a victim of sexual abuse, if so, when and for how long? _____
_____
_____

Have you ever been in counseling, if so, please state the name of therapist, dates and presenting problems for counseling?

1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever been hospitalized in a psychiatric hospital, if so, please state date, length of stay and reason for hospitalization?
_____
_____
_____

Have you ever been diagnosed with a mental health diagnosis, if so, which and when?

1. _____
2. _____
3. _____

Describe your family history of mental conditions (depression, anxiety, bi-polar, schizophrenia, obesity, etc.)?

1. Mother: _____
2. Father: _____
3. Sister: _____
4. Sister: _____
5. Brother: _____
6. Brother: _____
7. Grandmother (Maternal): _____
8. Grandfather (Maternal): _____
9. Grandmother (Paternal): _____
10. Grandfather (Paternal): _____
11. Other: _____
12. Other: _____

Have any of the above family members been in a psychiatric hospital, if so, please describe in detail?

_____
_____
_____

Describe your family history with drug or alcohol abuse (problem, how long, did they get treatment)?

13. Mother: _____
14. Father: _____
15. Sister: _____
16. Sister: _____
17. Brother: _____
18. Brother: _____
19. Grandmother (Maternal): _____
20. Grandfather (Maternal): _____
21. Grandmother (Paternal): _____
22. Grandfather (Paternal): _____
23. Other: _____
24. Other: _____

Described treatment for any family members who struggled with drug or alcohol addiction?

_____
_____
_____

Has anyone in your family ever had weight loss surgery, if so, what type and when? _____

_____

Have you ever been arrested, if so, for what and when? _____

_____
_____

What do you see as problems in your life, please describe?:

1. _____
2. _____
3. _____
4. _____
5. _____

What are the best things going on for you now? _____
_____
_____

What are the worst things going on in your life right now? _____
_____
_____

What is your attitude towards the future, please describe? _____
_____

Describe the high points of your life?

1. _____
2. _____
3. _____
4. _____
5. _____

Describe the low points of your life?

1. _____
2. _____
3. _____
4. _____
5. _____

Who are the significant people in your life? _____
_____

Do you have any phobias (fears) or compulsions, if so, please describe?

1. _____
2. _____
3. _____

Do you feel depressed, if so, please describe? _____
_____
_____

Do you feel anxious or stressed, if so, please describe? _____
_____
_____

What helps you relieve your stress or calm you down? _____
_____

Have you ever experienced hallucinations or delusions, if so, please describe? _____
_____

Do you have any sleep problems, if so, please describe? _____
_____

What do you do for relaxation? _____

Describe your feelings about your family members:

1. Mother: _____
2. Father: _____
3. Sister: _____
4. Brother: _____
5. Other: _____

Describe how food was used in your family: _____
_____
_____

Are you married, if so, how long? _____ Divorced?: _____

Is your relationship satisfying to you, please describe? _____
_____
_____

Are you involved with any clubs or organizations? _____

Do you volunteer with any organization, if so, please describe? _____
_____

Religion: _____ Are you involved in your church, synagogue, mosque, etc, if so, please describe? _____
_____

Do you feel satisfied with your job, please describe? _____
_____

Are you having financial problems? _____

Are you involved in any law suits, if so, please describe, past or present?

_____

_____

Level of education: _____

If you could change 5 things about yourself what would that be?

1. _____
2. _____
3. _____
4. _____
5. _____

Please describe your current goals:

1. _____
2. _____
3. _____
4. _____
5. _____

Please check any of the following conditions that apply to you or your family:

Medical Conditions

You	Family		You	Family	
_____	_____	Thyroid Disease	_____	_____	Diabetes
_____	_____	Kidney Disease	_____	_____	Cancer
_____	_____	Heart Disease	_____	_____	Prostate Problems
_____	_____	Neurological Condition	_____	_____	Glaucoma
_____	_____	Infectious Disease	_____	_____	Epilepsy
_____	_____	Gastrointestinal Disease	_____	_____	Asthma
_____	_____	Hypoglycemia	_____	_____	High Blood Pressure
_____	_____	Stroke	_____	_____	Other _____

Substance Use

Kind	Frequency	Method Used	Amount Used	Date of Last Use
Caffeine				
Nicotine				
Alcohol				
Beer				
Wine				
Liquor				
Marijuana				
Cocaine				
Heroin				
Crystal Meth				
Amphetamine				
Hallucinogen				
Prescription				
Prescription				
Diet Pills				
Laxatives				
Diuretics				

INFORMED CONSENT

By signing this document you are or you are giving consent for your minor child; willing participating in psychological treatment and am giving my Informed Consent for psychological treatment, which includes, but is not limited to, psychotherapy and psychological testing.

By signing below I have read and understood all of the questions above and agree that I am the person who has filled out this questionnaire and all questions are true and correct to my knowledge.

_____ _____

Signature of Patient Date

_____

Print Name