

COGNITIVE THERAPY AND CONSULTING ASSOCIATES

151 KALMUS DRIVE, SUITE B/220 • COSTA MESA, CA 92626 • (949) 675-0545 • FAX (714) 437-1687 • WWW.PSYHEALTH.NET

Please fill out the following questionnaire as completely as possible.
All information is confidential to the limits offered by California law.

Today's date: _____

Full Name: _____

Date of birth: _____

Address: _____
(Street, Apartment Number) (City) (Zip code)

Please provide telephone numbers below. For your confidentiality, list only numbers that are acceptable for your clinician to reach you directly or leave voice-mail messages.

Home phone (____) _____ Business phone (____) _____

Cellular phone (____) _____

Referred by: _____ Permission to thank referral source: yes no

How long have you lived in this area? _____ Birthplace _____

Religion _____

Occupation _____ Employed by _____

How long at present job _____

Military Service yes no Dates of Military Service _____

Years of education completed _____ Degree(s) earned: _____

Married: yes no Living together: yes no Years married/living together: _____

If married previously, please provide dates: _____

Do you have dependents? yes no If yes, how many? _____ Ages: _____

Please describe your reasons for seeking help. _____

How long has this bothered you? _____

Have you ever participated in counseling or psychotherapy before? yes no

Year(s) (e.g. 4/98-3/99)	Clinician name	Reason	Helpfulness: 0 to 10 (0: not helpful, 10: very helpful)

Have you ever had medication prescribed for psychiatric or emotional difficulties? yes no

If yes, please list below (please include current medications as well as medications used in the past):

Medication	Dosage	When (e.g. 1998-2002)	Prescribing M.D.

Date of last physical examination: _____

Please describe any health problems: _____

Do you smoke? No Yes How many/day? _____

Do you drink caffeinated beverages? No Yes How many cups/day? _____

Do you drink alcohol? No Yes How drinks per week? _____

Do you exercise regularly? No Yes How much per week? _____

Type of exercise? _____

PLEASE CHECK (☒) THE FOLLOWING AREAS IN WHICH YOU ARE HAVING DIFFICULTY:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> aggressive behavior | <input type="checkbox"/> divorce | <input type="checkbox"/> impulsiveness | <input type="checkbox"/> relaxation |
| <input type="checkbox"/> alcohol use | <input type="checkbox"/> drug use | <input type="checkbox"/> irritability | <input type="checkbox"/> self-control |
| <input type="checkbox"/> anger | <input type="checkbox"/> eating problems | <input type="checkbox"/> isolation | <input type="checkbox"/> self-esteem |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> education | <input type="checkbox"/> legal matters | <input type="checkbox"/> sexual problems |
| <input type="checkbox"/> assertiveness | <input type="checkbox"/> energy | <input type="checkbox"/> loneliness | <input type="checkbox"/> shame |
| <input type="checkbox"/> being a parent | <input type="checkbox"/> family | <input type="checkbox"/> making decisions | <input type="checkbox"/> shyness |
| <input type="checkbox"/> boredom | <input type="checkbox"/> fears | <input type="checkbox"/> marriage | <input type="checkbox"/> sleep |
| <input type="checkbox"/> bowel troubles | <input type="checkbox"/> finances | <input type="checkbox"/> memory | <input type="checkbox"/> stress |
| <input type="checkbox"/> career choices | <input type="checkbox"/> friends | <input type="checkbox"/> my thoughts | <input type="checkbox"/> sudden changes of mood |
| <input type="checkbox"/> children | <input type="checkbox"/> grief | <input type="checkbox"/> nervousness | <input type="checkbox"/> suicidal thoughts |
| <input type="checkbox"/> chronic pain | <input type="checkbox"/> guilt | <input type="checkbox"/> nightmare | <input type="checkbox"/> upsetting memories |
| <input type="checkbox"/> concentration | <input type="checkbox"/> headaches | <input type="checkbox"/> panic | <input type="checkbox"/> unhappiness |
| <input type="checkbox"/> dating skills | <input type="checkbox"/> health worries | <input type="checkbox"/> perfectionism | <input type="checkbox"/> work |
| <input type="checkbox"/> depression | <input type="checkbox"/> health problems | <input type="checkbox"/> relationships | <input type="checkbox"/> worry |

List the people currently living in your home (Include pets, if desired):

Name	Age	Relationship	Occupation

Please list your goals for treatment:

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

Please add any additional information you think would be useful. _____

Thank you for completing this form.

EMERGENCY CONTACT INFORMATION

(by providing this information you are authorizing CTCA to disclose information about you to the below listed party)

Name: _____ Relationship: _____

Address: _____

(Street)

(City)

(State, Zip code)

Telephone: (home): _____ (cellular): _____

(other): _____