COGNITIVE THERAPY ORANGE COUNTY

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Please fill out the following questionnaire as completely as possible. Today's date: _____
All information is confidential to the limits offered by California law.

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:

☐ aggressive behavior
☐ alcohol use
☐ anger
☐ anxiety
☐ assertiveness
☐ being a parent
☐ boredom
☐ bowel troubles
☐ career choices
☐ children
☐ chronic pain
☐ concentration
☐ dating skills
☐ depression
☐ divorce
☐ drug use
☐ eating problems
☐ education
☐ energy
☐ family
☐ fears
☐ finances
☐ friends
☐ gambling
☐ grief
☐ guilt
☐ headaches
☐ health worries
☐ health problems
☐ impulsiveness
☐ internet use
☐ irritability
☐ isolation
☐ legal matters
☐ loneliness
☐ making decisions
☐ marriage
☐ medication misuse
☐ memory
☐ my thoughts
☐ nervousness
☐ nightmare
☐ panic
☐ perfectionism
☐ relationships
☐ relaxation
☐ self-control
☐ self-esteem
☐ sexual problems
☐ shame
☐ shyness
☐ sleep
☐ stress
☐ sudden changes of mood
☐ suicidal thoughts
☐ upsetting memories
☐ unhappiness
☐ work
☐ 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 CTOC to disclose information about you to the below listed party)

Name:_____ Relationship: _____

Address:_____

(Street) (City) (State, Zip code)

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

(other): _____