PATHWAYS
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PATIENT QUESTIONNAIRE

This questionnaire is designed to help us build a solid foundation for our therapeutic work together. By responding to these questions as thoroughly as you can, you will be:

- Providing me with relevant background information.
- Helping me to get to know you in a more efficient and effective way.
- Reducing the amount of time we will need to spend reviewing basic information in our first few sessions.
- Preparing to develop a therapeutic plan for our work together.

Some items on this questionnaire may not pertain to you- please feel free to skip those. If you need additional space to answer any of the questions, please use the back of the page. If there is a question you do not wish to answer in writing, please leave it blank and we can discuss it together at our next session.

This questionnaire, and your responses (whether verbal or in writing), will become part of your clinical file and will be kept confidential.

Patient Name _____ DOB _____

Occupation/Year in School _____

Employer/School _____

Current Household

Please list current household members (if you live at school, please list family at home):
(continue on back if needed)

Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Members

Please list the members of the family with whom you were raised (parents/caregivers, siblings, etc.)
(continue on back if needed)

Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any children, stepchildren, or other close family members who do not live with you?
Y _____ N _____
If yes, please list below: (continue on back if needed)

Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Academic and Work History

Please list the last completed grade/degree(s) in school: _____

Are you currently in school or training? Y _____ N _____ If yes, please describe:

_____

Please provide a brief summary of your school and work history:

_____

_____

_____

_____

_____

Psychological History

Have you attended therapy in the past? If so, please provide a brief summary:

_____

_____

_____

Are you currently taking any psychiatric medications? Y _____ N _____
If yes, please list below:

Medication	Dosage	Prescribing Doctor	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any psychiatric hospitalizations? Y _____ N _____
If yes, please list below (dates can be approximate; use back if needed):

Date(s)	Hospital	Reason for Hospitalization
_____	_____	_____
_____	_____	_____

Is there a family history of any psychological disturbance or treatment (including depression, anxiety, mania, hallucinations, psychosis, nervous breakdown, suicide, or any other emotional disturbance)? If so, please describe: (please note, addictive behaviors are addressed in a later section)

_____

_____

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_____

Medical History

Have you had a physical exam within the last year? Y _____ N _____

Do you have any serious medical concerns? If so, please describe (use back if needed):

_____

_____

_____

Are you currently taking any medications for medical (non-psychiatric) reasons? Y _____ N _____
If yes, please list below:

Medication	Dosage	Prescribing Doctor	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any drug allergies? Y _____ N _____ If yes, please describe:

_____

Have you had any medical hospitalizations? Y _____ N _____
If yes, please list below (dates can be approximate; use back if needed):

Date(s)	Hospital	Reason for Hospitalization
_____	_____	_____
_____	_____	_____

Is there a family history of any major medical and/or hereditary issues (including cancer, heart attack or disease, stroke, seizures, diabetes, thyroid problems, dementia, Parkinson's, Alzheimer's, autoimmune disease)? If so, please describe:

_____

_____

_____

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_____

Alcohol, Substance Use, and Addiction History

Do you currently drink alcohol? Y _____ N _____ If yes, please describe amount and frequency:

_____

_____

Do you currently use any recreational drugs (including marijuana), or medications not prescribed for you? Y _____ N _____
If yes, please describe amount and frequency:

_____

_____

Have you ever had concerns about your own alcohol or substance use, or any type of addictive behavior (such as gambling, Internet use, etc.)? Have others ever expressed any concern about your behavior in these areas to you? If so, please describe:

_____

_____

Is there any family history of problems with alcohol use, substance use, or addictive behaviors? If so, please describe:

_____

_____

_____

Significant Life Events

Are there any other experiences or life events that you'd like to tell me about- experiences that were formative in shaping who you are today, and which would help me to know you better? (These could include both positive and more difficult events, such as accomplishments, awards, military service, volunteer work, losses, trauma, transitions, moves, living/working abroad, etc.)

_____

_____

_____

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_____

Support System/Network

Please describe who and what you can rely on for support in your life (family, friends, pets, hobbies, spiritual/religious beliefs, church or community involvement, activities, etc.)

_____

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_____ _____

Patient Signature Date

Revised July 2018