Boulder Community Health

Outpatient Rehabilitation Services
Patient Questionnaire – Counseling

1. Current health status: ❒ Excellent ❒ Very Good ❒ Fair ❒ Poor
2. Reason for seeking therapy: _____

   _____

   _____
3. What do you consider some of your strengths? _____

   _____
4. What do you consider some of your weaknesses? _____

   _____
5. Allergies (Drug, Food, Environmental): _____

   _____
6. Have you ever been prescribed psychiatric medication? ❒ Yes ❒ No

   If yes, please list medications and provide dates: _____

   _____
7. Are you using sleep medication? ❒ Yes ❒ No

   If yes, name of medication/supplement: _____
8. Other current medications and supplements: _____

   _____

   _____
9. Significant medical history: _____

   _____

   _____
10. Significant surgical history: _____

    _____

    _____
11. Diagnostic tests performed: ❒ CT Scan ❒ MRI ❒ Neuropsychological Testing

    _____

    _____

_____

Patient Label or Name and DOB

12. Loss of consciousness: ❒ Yes ❒ No

    If yes, estimated duration of loss of consciousness: _____

13. Prior Mental Health Therapy/Counseling? ❒ Yes ❒ No

    ❒ If yes, previous therapist: _____

14. 2 or more falls in the past year? ❒ Yes ❒ No Any fall with injury in the past year? ❒ Yes ❒ No

15. Hand dominance: ❒ Left ❒ Right ❒ Mixed

16. How many days/week do you exercise? _____

17. Living arrangements:

    ❒ Alone
    ❒ With Significant Other
    ❒ With Spouse
    ❒ With Minor Child(ren)
    ❒ With Adult Child(ren)
    ❒ With Parent(s)

18. Type of residence:

    ❒ Apartment
    ❒ Condo/Townhouse
    ❒ Dormitory
    ❒ Group Home
    ❒ Homeless
    ❒ House
    ❒ Mobile Home
    ❒ Other: _____

19. Household management: ❒ Independent ❒ Assistance Required ❒ Dependent

20. Education:

    ❒ Some High School
    ❒ High School Graduate/GED
    ❒ Some College
    ❒ Trade/Technical/Vocational Training
    ❒ College Graduate
    ❒ Post Graduate

    Name of college:_____ Major:_____

21. Learning problems: ❒ Mathematics ❒ Reading ❒ Writing ❒ Spelling

22. We will be providing education and recommendations. How do you learn best?

    ❒ Doing/Participation ❒ Listening/Discussion ❒ Reading/Handouts ❒ Visual/Demonstration

23. Occupation: _____

24. Work Status:

    ❒ Full Time
    ❒ Part Time
    ❒ Work from Home
    ❒ Homemaker
    ❒ Volunteer
    ❒ Retired
    ❒ Unemployed
    ❒ Disability
    ❒ Student

_____

Patient Label or Name and DOB

25. Appetite:

❒ No Changes ❒ Forget to Eat

❒ No Appetite ❒ Gained Weight

❒ Increased Appetite ❒ Lost Weight

❒ Decreased Appetite

26. Alcohol use: ❒ None ❒ Socially ❒ Weekly ❒ Daily

Amount: _____

27. Smoker: ❒ Yes ❒ No

28. Recreational drug/Marijuana use: ❒ Yes ❒ No

If yes, amount: _____

29. Sleep:

❒ No Problems ❒ Intermittent Awakening

❒ Awaken Fatigued ❒ Insomnia

❒ Difficulty Falling Asleep ❒ Nightmares

❒ Restless Sleep

30. Usual number of hours of sleep: _____

31. Usual bedtime: _____ Usual wake up time: _____

32. Hearing:

❒ No Difficulties ❒ Tinnitus (Ringing in the Ears)

❒ Decreased Hearing Acuity ❒ Sensitivity to Noise

33. Vision:

❒ Glasses for Reading ❒ Decreased Peripheral Vision

❒ Glasses for Vision ❒ Double Vision

❒ Contact Lenses ❒ Headaches with Reading

❒ No Difficulties ❒ Sensitivity to Light

❒ Blurry Vision

34. Relationship Status:

❒ Single ❒ Dating ❒ Married ❒ Separated ❒ Divorced ❒ Widowed

35. On a scale of 1-10, how would you rate your relationship?

❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10

Poor Great

_____

Patient Label or Name and DOB

36. Family psychiatric history: ❒ Yes ❒ No

37. Family history of panic or anxiety: ❒ Yes ❒ No

38. Family substance abuse history: ❒ Yes ❒ No

39. Family suicide attempts: ❒ Yes ❒ No

40. What significant life changes/stressors have you experienced lately? _____

_____

_____

41. Do you have any cultural or spiritual concerns that we should consider during your therapy? _____

_____

42. Do you feel safe at home? ❒ Yes ❒ No

_____

Patient Signature Date/Time

Thank you! Please turn this questionnaire in to the Outpatient Rehabilitation check in desk during the check in process the day of your evaluation.

_____

Patient Label or Name and DOB