Questionnaire

Have you ever been hospitalized for a psychiatric issue?

Yes

No

Is there a history of mental illness in your family?

Yes

No

If you are in a relationship, please describe the nature of the relationship and months or years together.

Describe your current living situation. Do you live alone, with others. With family, etc...

What is your level of education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it?

Please check any of the following you have experienced in the past six months

Increased appetite

Decreased appetite

Trouble concentrating

Difficulty sleeping

Excessive sleep

Low motivation

Isolation from others

Fatigue/low energy

Low self-esteem

Depressed mood

Tearful or crying spells

Anxiety

Fear

Hopelessness

Panic

Other

Please check any of the following that apply

Headache

High blood pressure

Gastritis or esophagitis

Hormone-related problems

Head injury

Angina or chest pain

Irritable bowel

Chronic pain

Loss of consciousness

Heart attack

Bone or joint problems

Seizures

Kidney-related issues

Chronic fatigue

Dizziness

Faintness

Heart valve problems

Urinary tract problems

Fibromyalgia

Numbness & tingling

Shortness of breath

Diabetes

Hepatitis

Asthma

Arthritis

Thyroid issues

HIV/AIDS

Cancer

Other

What else would you like me to know?

How did you hear about NuWave Counseling?

Facebook

Google Search

Our Podcast

Youtube

Friend/Family

Other

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can

What are your goals for counseling?

Have you seen a mental health professional before?
Yes

No

Specify all medications and supplements you are presently taking and for what reason.

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

Who is your primary care physician? Please include type of MD, name and phone number.

Do you drink alcohol?
Yes

No

Do you use recreational drugs?
Yes

No

Do you have suicidal thoughts?
Yes

No

Have you ever attempted suicide?
Yes

No

Do you have thoughts or urges to harm others?

Yes

No