Moment to Moment LLP

Self Questionnaire

Please take a few minutes in completing the following questions. Your completion will help your therapist to better understand you and your situation. In addition, the information below will help in utilizing your appointment time more efficiently.

Client Name: _____ Date of Birth: _____

Parent(s) or Guardian Name (if client is under 18):

_____

Current Grade/Highest Education Received: _____ Employer/School:

Who referred you to us?

_____

What is the reason for your referral?

_____

_____

What are you hoping to gain from therapy at this time?

_____

_____

Until now, how have you attempted to solve the problem? How successful have those solutions been for you?

_____

_____

_____

Have you ever seen a mental health professional or been hospitalized for psychiatric reasons? Please explain:

_____

Are you currently being treated for any medical conditions? Please explain & list any doctors you work with:

_____

_____

_____

Please list any current medications you are being prescribed:

Medication	Reason for Prescription	Date of First Use	Dosage	Frequency	Method	How do you like this medication? Is it working for you?

Please check any of the following conditions that you have a history of in you or in your immediate family:

	Condition	Self	Family Member (specify)
☐	Depression		
☐	Anxiety		
☐	Bipolar Disorder		
☐	Personality Disorder		
☐	Schizophrenia		
☐	Posttraumatic Stress Disorder (PTSD)		
☐	Alcohol or other drug abuse		

Is there any other information about you that you would like us to know?

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_____

_____

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