Personal Information Questionnaire

The Emotional Health CBT Clinic
Cognitive Behavior Therapy since 1972

Name

Address

Age

TELEPHONES

IS IT OK TO LEAVE A MESSAGE?

Home	Yes ☑	No ☐
Mobile	Yes ☐	No ☑
Work	Yes ☐	No ☐
E-mail	Yes ☑	No ☐

PERSON TO CALL IN CASE OF EMERGENCY

Name

Tel.

1. HEALTH

Date of birth DD MM YYYY

Place of birth

Do you consider yourself generally healthy?

When was your last medical check-up, and what were the results?

Health/illnesses during childhood/adolescence:

Have you had any surgeries or accidents?

Do you suffer from any chronic condition?

Please list any current health issues and the medication you are taking to treat them:

How is your sleep?

How is your appetite?

HABITS

Do you smoke cigarettes? ☐ Yes ☐ No

If so, how many per day? _____

Since when have you been smoking? _____

Do you drink alcohol? ☐ Yes ☐ No

If so, how much? _____

Does your spouse drink alcohol? ☐ Yes ☐ No

If so, how much? _____

Do you take drugs on a regular basis?
(recreational drugs and/or over the counter products) ☐ Yes ☐ No

If so, how much? _____

2. FAMILY OF ORIGIN

FATHER

Name _____ Age _____ Father's occupation _____

Health (if deceased: circumstances and how the loss affected you):

_____

Describe your father's personality and the nature of your relationship with him past and present:

_____

_____

MOTHER

Name _____ Age _____ Mother's occupation _____

Health (if deceased: circumstances and how the loss affected you):

_____

Describe your mother's personality and the nature of your relationship with her past and present:

_____

_____

SIBLINGS

Name		Age		Occupation	
Name		Age		Occupation	
Name		Age		Occupation	
Name		Age		Occupation	
Name		Age		Occupation	
Name		Age		Occupation	

Describe your relationship with your siblings (past and present):

Were there other adults significantly involved in your upbringing? ☐ Yes ☐ No

How?

Describe the atmosphere in your childhood home:

Describe yourself as a child:

Did or does any member of your family suffer from alcoholism or drug abuse or some form of mental illness? Was or is any member of your family anxious or depressed?

Describe any fearful, distressing or traumatizing thoughts or experiences not already mentioned.

3. OCCUPATION AND EDUCATION

What is your education? _____

Did you like school as a child/teen? _____

Did you do well? _____

How well did you relate to other kids or teens? _____

Were you ever bullied or given nicknames? _____

What work do you presently do? _____

What do you enjoy about your work? _____

Is it stressful? _____

If so, what is stressful: work relationships or the work itself? _____

Do you tend to procrastinate? _____

4. ROMANTIC RELATIONSHIPS

Are you currently in a relationship? _____

How long have you been with your partner? _____

Do you live with your partner? _____

Are you married? _____

What is your partner's age? _____

His/her occupation? _____

Describe your partner's personality: _____

_____

_____

In what areas is there compatibility? _____

_____

In what areas is there incompatibility? _____

_____

How many children do you have (please list)? _____

Do they live with you? _____

Describe the atmosphere in your home: _____

_____

_____

Give details on any previous marriages or long-term relationships:

5. SELF-DESCRIPTION

How would you describe yourself?

What situations make you feel calm and relaxed?

How do you unwind?

What situations make you feel agitated, fearful, worried or panicky?

How do you cope?

What are you most pleased with about yourself?

What are you least pleased with about yourself?

Past and current interests, hobbies, activities: how is most of your free time spent?

Do you exercise?

Do you make friends easily?

Do you keep them?

6. CURRENT PROBLEM(S)

This section may overlap with what you already discussed in the verbal part of the assessment, but please see it as an opportunity to reflect and add any info you may not have had the chance to share in the verbal interview.

State in your own words the nature of the problem for which you are seeking help at the clinic.

Give a brief account of the history and the development of your chief complaint from its onset to the present time:

How is it affecting you (at work, with your family, in school… in your overall functioning)?

On a scale of 0 to 10, 10 being most severe, how severe is your problem? _____

What makes it better? _____

What makes it worse? _____

When was the last time you felt well both physically and emotionally?

Have you previously sought therapy for this problem? _____

Did it help?

Have you previously sought help for other problems?

What made you decide to seek help now?

7. THERAPY

In your own words, what constitutes a good therapy? What is the role of the therapist and yours?

What personality traits and characteristics should a good therapist possess?

How would you describe the interactions between a good therapist and his/her clients?

What do you think therapy will bring you and how long do you think it should last?

Do you have any fear not previously mentioned?

How is your self-esteem/self-confidence?

Can you be assertive?

Who referred you to the clinic?

How did they figure you could benefit, and what did they tell you about us or about cognitive-behaviour therapy?

_____

_____

If you are self-referred, how did you find us? _____

How did you know cognitive-behaviour therapy was what you needed?

_____

_____

Do you have a GP or psychiatrist? _____

If so, what is his/her name? _____

Would you like for us to be in contact with him/her?
(or any other professional involved in your care) _____

If so, and if you have not done so, please provide us with his/her contact information below:

_____

_____

8. AVAILABILITIES

Please indicate when you are available for your therapy sessions. We kindly ask you to please give us as many availabilities as possible. Please note, however, that there is an extra fee of $20 for sessions that take place in the evening (starting at 5:00 pm).

Mondays: _____

Tuesdays: _____

Wednesdays: _____

Thursdays: _____

Fridays: _____

9. QUALITY ASSURANCE

We value your feedback. Your wellbeing is our priority. In order to help us offer you the best quality of care possible, we would like to contact you during the months that will follow your evaluation to ask you a few questions on the quality of the services received. These calls are made exclusively by the director of the clinic, Dr. Luisa Cameli and/or our coordinator, Mrs. Ronit Milo, and are expected to take no longer than ten minutes at a time that is convenient for you. The information gathered will remain confidential and your therapist will receive the average score (e.g., punctuality 9/10) and list of comments from many clients.

I consent to be contacted: _____ (signature)