



INTENSIVE OUTPATIENT QUESTIONNAIRE

Please complete and bring to your first assessment session.

Name _____ DOB _____ Date _____

Reason for seeking treatment at this time: _____

Referral Source:

Name _____

May we contact? Yes _____ No _____

Address _____

Phone _____ Fax _____

Psychiatrist:

Name _____

May we contact? Yes _____ No _____

Address _____

Phone _____ Fax _____

Primary Care Physician:

Name: _____

May we contact? Yes _____ No _____

Address: _____

Phone _____ Fax _____

Psychologist, Therapist or Counselor:

Name _____

May we contact? Yes _____ No _____

Address: _____

Phone _____ Fax _____

Current medications (psychiatric and non-psychiatric) medication(s) and dosage:

Religious, spiritual and cultural orientation and possible impact on treatment: _____

Community resources/support (AA, NA, church, etc.): _____

Family history of psychiatric and or alcohol/chemical dependency problems: relative and symptoms or diagnosis _____

Please describe your strengths and assets: _____

Please describe any perceived weakness or limitations: _____