DR. SHEILA KHALEGHIAN

CLINICAL PSYCHOLOGIST

BEHAVIORAL HEALTH QUESTIONNAIRE

The purpose of this questionnaire is to assist in evaluating your present problem. This task requires you to answer each question as fully and accurately as possible. This information is protected and kept strictly confidential.

Name: ______________________________ Date of Birth: __________ Age: ______

Address: ______________________________ City: ______________________

State: ______ Zip Code: __________ Male / Female Sexual orientation: ______________

Cell #: ________________ Home #: ________________ Work #: ____________

Email Address: ____

☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed

Do you have children? ☐ No ☐ Yes Who lives with you in your home? (Fill out below)

Name: ______________ Relationship: __________ Age: ______ Occupation: __________

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Name: ______________ Relationship: __________ Age: ______ Occupation: __________

Name: ______________ Relationship: __________ Age: ______ Occupation: __________

In case of an emergency, please contact: ________________________________

Contact #: ______________ Relationship to Client: ________________________

Insurance Carrier: ____________________ Policy / ID# ____________________ Group #: ____________________

Insured's Name (if different from client): __________________________ Date of Birth: ___________________

Who referred you to Dr. Khaleghian? ____

1. What specific problems/concerns bring you in for an evaluation at this time? _____________________________

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2. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No ☐ Yes, name of therapist/practitioner ____

3. Are you currently taking any prescription medication? ☐ No ☐ Yes

If yes, please list ____

4. In the last 3 months have you noticed any change in the following? If yes, please describe below:

Sleep ____

Appetite ____

Weight ____

Energy Level ____

Memory/Concentration ____

Sex Drive ____

Spirituality ____

Nervousness ____

Work ____

Relationships ____

Family Relationships ____

Physical Health ____

5. In the PAST YEAR have you experienced any of the events listed below?

- ☐ Death of spouse/partner
- ☐ Divorce
- ☐ Marital separation
- ☐ Legal problems
- ☐ Death of close family member (except spouse)
- ☐ Major personal injury or illness
- ☐ Marriage
- ☐ Loss of job
- ☐ Retirement
- ☐ Illness of family member
- ☐ Financial problems
- ☐ Been hit, kicked, punched or otherwise hurt by someone
- ☐ Pregnancy
- ☐ Sex difficulties
- ☐ Death of close friend
- ☐ Serious marital problems
- ☐ Son or daughter leaving home
- ☐ Trouble with in-laws
- ☐ Trouble with boss
- ☐ Change in residence
- ☐ Change in schools
- ☐ Change in job or job responsibilities
- ☐ Trouble with adult children
- ☐ Trouble with minor children
- ☐ Caring for seriously ill/disabled relative/friend

6. Do you drink alcohol? ☐ No ☐ Yes How Often? ______________________________

7. Drug Use ☐ None

☐ Tobacco/Nicotine ☐ Marijuana ☐ Methamphetamines ☐ Cocaine/Crack ☐ Stimulants

☐ Sedatives ☐ Opiates ☐ Hallucinogens ☐ Abuse of Prescription Medication

8. Has your substance use ever felt like a problem to you? ☐ No ☐ Yes

9. Have you received drug or alcohol treatment before? ☐ No ☐ Yes

If yes, where and when? ______________________________

10. Have you been hospitalized for a psychiatric illness? ☐ No ☐ Yes

If yes, please explain: ____

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11. What would you like to accomplish out of your time in therapy?

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