Albuquerque Psychiatry & Psychology, LLC
4308 Carlisle Blvd. NE, Ste. 210, Albuquerque, NM 87107
Phone: 505-247-1921 Fax: 505-247-1020

Initial Visit Questionnaire (Adult) *page 1 of 2*

Provider Name:		**Date:**
Patient Name:	**D.O.B.**	**Age:**

Client's Marital Status: __ Married __ Partnered __ Single__ Divorced __ Separated

Number of Children _____ Ages _____

Reason for seeking Therapy:

Previous therapy? __ yes __ no **Name (s) of Therapists**_____

Traumatic events (include: abuse/or neglect)

Family psychiatric history

Allergies

Current Suicidality _____ **Current Homicidally** _____

Past history of Suicidality

Do you exercise?_____ **Problems with sleep?**_____

Cigarette or tobacco use? _____

Recreational drinking? ____ yes ____ No **What kind & how much?** _____

Recreational drug use? ____ yes ____ No **What kind & how much?** _____

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Initial Visit Questionnaire (Adult) *Continued page 2 of 2*

Provider Name:		Date:
Patient Name:	D.O.B.	Age:

Religious/Spiritual affiliations

Social Supports

Medical problems

Medical history (hospitalizations, surgeries?)

Current Medications

Medication	Dose	Frequency	Why prescribed?	Who prescribed?

Nutritional problems (weight loss/weight gain, etc.)

Legal problems

Current Employment

Employment history (previous 5 years)

Goals of Therapy?

Signed

(Patient's Signature or authorized person) **Date**