Pacific Bay Integrative Health Center

GENERAL INFORMATION QUESTIONNAIRE ***(please complete both sides)***

Today's Date: _____

Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Pronouns: _____

Address: _____

City, State, ZIP: _____

Phone (H): _____ Phone (C): _____ Phone (W): _____

How did you hear about PBIHC? _____

Emergency Contact Information

Name: _____ Home Phone: _____

City & State: _____ Other Phone: _____

Relationship to you: _____

Current Employment Status - Please circle all that apply

Employed Self-Employed Unemployed Student Disabled Retired Other _____

Primary means of support: _____

Medical Information

Date of most recent physical exam: _____

General Health: Excellent ( ) Good ( ) Fair ( ) Poor ( )

Please list any medications you currently take, including prescribed medications. Also include over the counter medications, vitamin/mineral supplements, medicinal herbs, and homeopathic remedies.

_____

_____

_____

Please describe any physical/medical problems, past or present, and indicate whether past or present:

_____

_____

Are you currently being treated for any of the problems listed above? Yes ( ) No ( )

If yes, for which? _____

Who is treating you for these problems? _____

Are you currently seeing a psychiatrist? Yes ( ) No ( ) Have you ever seen a psychiatrist? Yes ( ) No ( )

If yes, when? _____ Why? _____

Please turn over and continue questionnaire.

Please list any psychiatric medication you have ever been prescribed – name of medication, how long taken, and was it helpful? _____

_____

Relationship Status

Single ( ) Separated ( ) Divorced ( ) Widowed ( ) Married ( ) Partnered ( ) Other ( )

Describe Other: _____

Children/Step-Children

No ( ) Yes ( ) If yes, please provide name(s) & age(s): _____

_____

Others Living In Household

Name	Relationship	Age	Comments

Religious/Spiritual Affiliation: _____

Race/Ethnicity: _____

How do you describe your sexual orientation? _____

Why are you seeking therapy/counseling? _____

When did you start feeling this way? _____

Have you ever been in therapy/counseling before? Yes ( ) No ( )

If yes, when and what were the most helpful and least helpful aspects of your prior therapeutic experience(s)?

_____

_____

What are your goals for therapy? _____

_____

Describe your areas of strength: _____

_____

Is there anything else you would like your therapist to know about you or that you would like to add? _____

_____

Thank you for taking the time to complete this questionnaire.