LARA FIELDING, PSY.D., ED.M.
1964 WESTWOOD BLVD., SUITE 310 • LOS ANGELES, CALIFORNIA 90025
310.963.1773

All questions contained in this questionnaire are strictly confidential and will become part of your medial record

Name: _____ DOB:_____

PAST & PRESENT GENERAL MEDICAL OR PSYCHIATRIC DIAGNOSES:

DIAGNOSIS	DATE	TREATMENT/MEDICATION & EFFECTS

PAST PSYCHIATRIC OR REHABILITATION HOSPITALIZATIONS

Year	Reason	Hospital

PRESCRIBTION, OVER THE COUNTER DRUGS, & SUPPLEMENTS CURRENTLY BEING TAKEN

Name of Drug	Strenth	Frequency Taken	How long?

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HEALTH BEHAVIORS

EXERCISE	How often to you *currently* engage in moderately strenous exercise?
	Are you getting more or less exercise than usual?
	What types of exercise to you do?
DIET	Please describe typical breakfast, lunch, dinner and snacks eaten.
	What are your eating habits like generally?
Relaxation	Do you meditate, or practice other self soothing exercises? Please list.
Sleep	Are your sleep patterns regular? Yes/No How many hours sleep per night do you need? _____ actually get ____
Caffiene	# of cups of coffee per day? _____ Tea?_____ # of caffinated sodas per day? _____
Alcohol	# of alcoholic beverages per week? _____ Types of alcoholic beverages consummed? (e.g. beer/wine, hard liquor)
	Are you concerned about the amount you drink? Yes/No
	Have others in your life expressed concern? Yes/No
	Have youever experienced blackouts? Yes/No
	Do you engage in “binge” drinking? Yes/NO
Drugs	Do you currently use recreational or street drugs? If so, which one(s) and how often?
	Have you ever used recreational or street drugs? If so, when, how often?
	Are you currently in a sobriety program?
Tobacco	Do you smoke cigarrettes? If so, how many per day?
Other	Are there any other health behaviors (or unhealthy behaviors) of which I should be aware?

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FAMILY MENTAL HEALTH HISTORY

Has anyone in your family attempted suicide? If so, who and how?

Has anyone in your family been hospitalized for psychiatric reasons? If so, who and why?

Are you aware of any history of mental illness/ mental health related difficulties in your family?

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

Sypmtom	Yes	No
Depression		
Lack of interest in things you used to have interest		
Irritable		
Physically restless or agitated		
Excessive worry or rumination		
Disrupted sleep Please describe:		
Poor concentration		
Poor memory		
Difficulties getting motivated		
Trouble completing tasks		
Becoming overwhelmed by making decisions		
Chronic pain		
Withdrawn/Isolated		
Fatigue		
Panic attacks		
Anxiety in social situations		
Fear/avoidance of particular social situations (please list)		
Rage		
Weight changes		
Appetite changes		
Suicidal thoughts		
Have you ever tried to commit suicide?		

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Symptom	Yes	No
Have you ever cut yourself intentionally?		
Tendency to become violent?		
Do you experience intrusive, unwanted thoughts/images that keep coming back no matter how much you try to stop them?		
Irresistible ugres to perform rituals (check, touch, count, clean)		
Periods of euphoric, on top of the world feelings, with boundless energy, talkative, invincible, impulsive or agitated, with racing thoughts		
Eat large quantities of food in one sitting and then cause yourself to throw up or us laxatives?		
Ever hear voices or see visions that other people in the same room do not experience?		
Ever experience or witness a life-threatening event, assault or trauma?		
Recurrent nightmares or memories of the trauma		
Fear that someone or people are out to get you, are following you, or listening to your private conversations?		
Believe you have special powers?		
Believe you receive messages to you on TV, billboards, books?		
Steal things		