AUBURN BEHAVIORAL HEALTH, LLC

PERSONAL INVENTORY QUESTIONNAIRE

In order to plan the best services for you and/or your family it's important to gather some initial demographic and self-inventory information. Please respond to the following questions to the best of your ability. The more you are able to share about yourself, the better able we'll be to plan for your services together.

Name: _____ Date: _____

Address: _____
Street City State Zip

Mailing Address/P.O. Box (if different from above): _____

Preferred Phone: ( ) _____ Alternative Phone: ( ) _____

Do you give us permission to leave a message on your phone?

☐ Yes ☐ No

Do you give us permission to communicate via email?

☐ Yes ☐ No Email Address: _____

Do you give us permission to communicate with you via text messaging? ☐ Yes ☐ No

Date of Birth: _____ Age: _____ SSN: _____

What is your current gender identity? (Check ALL that apply)

☐ Male ☐ Female ☐ Transgender Referral Source: _____

Race: _____ Spoken Languages: _____

Emergency Contact: _____ Phone: ( ) _____
Relationship

Insurance Plan: _____

Insured ID or Contract Number: _____

Insured/Subscriber's Employer: _____

Subscriber's Name: _____
First Middle Last

Subscriber Address: _____
Street City State Zip Code

Subscriber's Phone Number: _____

Subscriber Date of Birth: _____ Subscriber's SSN: _____

Marital Status: Married ☐ Single ☐ Partnered ☐ Other ☐

Secondary Insurance Plan/Program: _____

Secondary Insured ID/Contract: _____

Military History: ☐ Yes ☐ No If yes, Highest Rank/Branch of Service _____

Educational Background: _____
Highest Grade Completed Number Years Undergraduate Graduate Degree

Occupation: _____ Annual Gross Income: _____

Current Employer(s): _____

Are you satisfied with your current job/position? ☐ Yes ☐ No

Any recent changes in your employment or job responsibilities? ☐ Yes ☐ No

If Yes, Explain: _____

Financial Concerns: _____

Previous Employers: _____

Have you had any significant periods of unemployment? ☐ Yes ☐ No

If Yes, Explain: _____

Current Living Situation: _____

Name of spouse/significant other, if applicable: _____

Phone number for spouse/significant other: ( )_____

History of Present Relationship (if applicable): _____

_____

Children's Names/Ages/Sex/Living Arrangements (if Applicable): _____

_____

History of Previous Relationships: _____

_____

_____

Describe the family you grew up in: _____

_____

_____

Who is the most important person in your life and why? _____

Religious/Spiritual Affiliation: _____

People come for therapy/treatment for any number of reasons, most commonly due to specific life stressors, uncomfortable or undesirable symptoms, or major life changes, to name a few. What brings you in for services now?

_____

_____

_____

_____

When did these concerns begin? _____ What was going on at the time? _____

_____

_____

Rate your current level of distress on a scale of 1 to 10, with 10 being the highest:

1 2 3 4 5 6 7 8 9 10

Has anyone recommended that you seek therapy? If so, who? _____

How long have you thought about coming in for therapy? _____

Have there been any obstacles to you making the decision to seek help? _____

_____

Have there been any recent events, or past events that remain unresolved that cause you discomfort, pain, or discontent? If so, explain:

_____

_____

How would you like your life to look differently in the next 3 - 5 years?

_____

_____

Family history of:

☐ Suicide ☐ Homicide ☐ Mental Illness ☐ Substance Abuse ☐ Intellectual Disability

If yes, explain: _____

Relevant Medical Background

Do you have concerns about your health? ☐ Yes ☐ No

If "yes", explain: _____

_____

Disabilities: No If "yes", explain: _____

Family physician: _____ Date of Last Visit/Why? _____

Pregnant: ☐ Yes ☐ No ☐ N/A Prenatal care: ☐ Yes ☐ No ☐ N/A

Seizures/History of Seizures: Yes No Currently Treated: Yes No

Any Allergies to Medications: Yes No

Other Allergies: _____

Current Medical Conditions: _____

Current Medications:

Prescription Medications	Strength/Dosage	Who Prescribed	Over the Counter

Take Medications as Prescribed: Yes No Height _____ Weight _____

Have you been in therapy before, or had any prior treatment for a mental health condition, including psychiatric hospitalizations. Yes No

Dates	Provider(s)	Type of Problem

Have you felt and wanted or needed to cut down on your drinking or drug use in the past year?

☐ Yes ☐ No

Has anyone objected to your drinking or drug use? OR has your family, a friend, or anyone else told you they objected to your alcohol or drug use? ☐ Yes ☐ No

Have you ever found yourself preoccupied with wanting to use alcohol or drugs? OR Have you found yourself thinking a lot about drinking or using? ☐ Yes ☐ No

Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger or boredom? ☐ Yes ☐ No

Significant Legal History: ☐ Yes ☐ No If Yes, Explain:_____

_____

Was your contact with us a result of a requirement by the Courts: ☐ Yes ☐ No

Have You Ever Been arrested: ☐ Yes ☐ No If Yes, Explain: _____

Have You Ever Experienced a Traumatic Event? ☐ Yes ☐ No If Yes, Explain: _____

_____

Abuse history:
☐ None ☐ Sexual ☐ Emotional ☐ Physical ☐ Domestic ☐ Elder

If Yes to any, Explain: _____

Do you have thoughts and behavior related to ☐ Suicide ☐ Homicide ☐ Aggression

If Yes, Explain: _____

Is there anything else that you feel it's important for your therapist to know about you that hasn't already been addressed? If yes, explain:

_____

_____

_____