Thrive
Healing Center for Children & Families
2542 S. Bascom Ave. Suite 125, Campbell CA 95008
408.963.6437 ph 408.963.6594 fax thrive-hcfc.org

New Patient Questionnaire

CONTACT INFORMATION

Patient's Name:_____ DOB: _____ Age: _____
Address: _____

Home phone: _____ Ok to text? _____ Ok to Leave a message? _____
Cell Phone: _____ Ok to text? _____ Ok to Leave a message? _____
Work: _____ Ok to text? _____ Ok to Leave a message? _____

Email address: _____ OK to send email? _____

Place of Employment: _____
Address for Employer: _____
Occupation/Work Title: _____
Employment Issues: _____
_____

Emergency contacts (name, relationship, and phone number):
_____
_____
_____

Child(ren) Name(s) & Age(s):
_____
_____

Other Member's of Household (names, ages, & relationship to patient):
_____
_____

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INSURANCE INFORMATION

Financially Responsible Person: _____
Address for Responsible Person: _____
Insurance Company Name: _____
Primary Card Holder: _____
Policy Number: _____
Group No. _____
Address: _____
Phone No. _____ Fax: _____
*** Note: Invoice with CPT codes will be provided at the end of each month for private pay clients upon client request. Payment for your session is due at the beginning of each session in the payment box in the waiting room.

REFERRAL CONCERNS

How did you hear about our practice? _____

What concerns have brought you to our office?

_____
_____
_____
_____

Estimate the severity of presenting concern: **Mild** **Moderate** **Severe** **Very Severe**

To what do you attribute these challenges?

_____
_____
_____

What goals would you like to set/meet regarding the presenting concern/problem?

_____
_____

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What areas of your life do you feel are affected by the presenting concern/ problem? Please describe
Home: _____
Work:_____
Health: _____
Relationships: _____
Marriage/Significant Other: _____

Describe any changes in your:
Energy: _____
Sleep: _____
Appetite: _____
Mood: _____

COLLATERAL PROVIDERS

Name of Primary Physician & Phone: _____
Other (Specialty, Name and Number) _____
_____

Sources of Support (social, economic, emotional):_____
_____
_____
_____

TREATMENT HISTORY

Previous Therapy: Yes____ No ___

Brief History of Previous Mental Health Treatment (name of provider, length and type of treatment, reason for terminating):_____
_____
_____
_____

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How was your experience with previous therapist?
Not at all satisfied 1 2 3 4 5 Very Satisfied

Have you ever been admitted to a psychiatric or treatment facility? If yes, when, concern and duration of stay?

_____
_____

History of mental health concerns and/or psychiatric disorders for family members?

_____
_____
_____

Medical conditions for you and immediate family members? If medical condition exists, describe current and history of treatment. Any physical health concerns?

_____
_____
_____

Describe substance abuse history for you and any immediate family members?

_____
_____
_____

Describe household and family structure:

_____
_____
_____
_____

Describe social supports/community/network:

_____
_____
_____
_____

Self-care activities that you engage in such as meditation, exercise, journaling, dancing, etc?

_____
_____