# Pre-therapy Questionnaire

The purpose of this questionnaire is to get a picture of your personal background. The information you provide facilitates our ability to work together and allows for a more effective use of your time. Your initial two hour assessment will explore the main reasons for seeking help at this time, gaining a thorough understanding of your history and identifying your goals for successful treatment. Please answer the questions as thoroughly and accurately as you feel comfortable. This information is strictly confidential and will not be released to any person, or agency without your consent, unless there is a requirement by law.

**Personal Information**

Name: _____ Date of Birth: _____
*Title/First/Last*

Address: _____

_____

_____ May I write to you at this address? Yes/No

Home Tel: _____ May I leave messages on this number? Yes/No

Mobile: _____ May I connect with you on this number? Yes/No

Email: _____ May I connect with you at this address? Yes/No

**General Practice (GP) Details:**

Name of GP: _____ Last seen: _____

Address: _____

_____

**Emergency Contact details:**

Name: _____ Relationship: _____

Tel: _____

**Consent to store data on a secure database?** Yes/No

**Medication**

Please list any medication you are currently taking (please include contraceptive medication):

| Medication and dose | Date commenced | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Legal History**

Have you ever been arrested or convicted of a crime (if yes, please detail, where, when, and what for)?

**Additional Information**

Are there any additional comments or information that you would like to include that has not been covered in the questionnaire?

**Thank you for completing this questionnaire**