the blossom method

Client Questionnaire

Name:_____

Please share with us what brought you to The Blossom Method:

_____
_____
_____
_____
_____

Have you had any previous psychological or psychiatric treatment? If yes, please complete the following:

Hospitalizations: (please include hospital, dates, doctor and reason for hospitalization)

_____
_____
_____

Outpatient therapy: (please include therapist name, dates, and reason)

_____
_____
_____

Medications: (please include medicine, dose, dates, and reason)

_____
_____
_____

Emergency Contact:_____

233 E. Erie Street #306
Chicago, Illinois 60611
312.854.0061
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Social History

Family (Please list parents, siblings spouse and children)
(name, age, sex, relationship and occupation/grade)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Circle highest level of education completed:
Grade School High School College Grad School

Medical History

Primary Care Physician:_____Phone:_____

Other physicians: _____

When was your last physical exam: _____

Please list any medical problems for which you receive treatment:

_____
_____

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Are you allergic to any medications? (If yes, please list)

_____
_____

Please describe the following:

Current/previous alcohol use (frequency/amount):

_____
_____
_____

Current/previous drug use (substance/frequency/amount):

_____
_____
_____

Caffeine:_____

Tobacco:_____

Exercise:_____

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