peoplefirst CLINIC, PLLC

652 Bielenberg Dr, Suite 202
Woodbury, MN 55125-4480

Phone: (651) 317-3902
Fax: (949) 890-4747
info@peoplefirstmn.com

Therapy Pre-Assessment Questionnaire

Thank you for choosing PeopleFirst for therapy. Your answers help your therapist get to know you before your first session. There are no right or wrong answers, and you can skip anything you'd rather talk about in person. Your therapist will go over this with you as part of your diagnostic assessment.

Questions, or need help or an interpreter? Email our business office at info@peoplefirstmn.com.

About you

Legal first name		**Legal last name**	
Chosen / preferred name		**Pronouns**	
Date of birth		**Phone**	

1. Past care

Have you received mental health care before (therapy, psychiatry, or other)?	☐ Yes ☐ No
Are you taking any prescription medication right now?	☐ Yes ☐ No
Have you ever been prescribed medication for your mental health?	☐ Yes ☐ No

2. Health and how you've been feeling

How would you rate your physical health right now?	☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good
Any health problems you are dealing with right now?	
How would you rate your sleep right now?	☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good
Any sleep problems you are noticing?	
Do you exercise?	☐ Yes ☐ No
Any changes or struggles with appetite or eating?	
Are you feeling overwhelming sadness, grief, or depression?	☐ Yes ☐ No
Are you dealing with anxiety, panic attacks, or phobias?	☐ Yes ☐ No
Are you living with chronic pain?	☐ Yes ☐ No
Do you drink alcohol more than once a week?	☐ Yes ☐ No
How often do you use recreational drugs?	☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never
Are you in a romantic relationship right now?	☐ Yes ☐ No

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If you are in a relationship, how would you rate it from 1 (poor) to 10 (exceptional)?	1 2 3 4 5 6 7 8 9 10
What big life changes or stressful events have you been through recently?	

3. Family mental health history

Has anyone in your family experienced any of the following? Share only what you're comfortable with.

Alcohol or substance use	☐ Yes ☐ No	**Obsessive-compulsive behavior**	☐ Yes ☐ No
Suicide attempts	☐ Yes ☐ No	**Domestic violence**	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	**Schizophrenia**	☐ Yes ☐ No
Depression	☐ Yes ☐ No	**Obesity**	☐ Yes ☐ No
Eating disorder	☐ Yes ☐ No		

4. Strengths and goals

Are you working right now?	☐ Yes ☐ No
Do you consider yourself spiritual or religious?	☐ Yes ☐ No
What are some of your strengths?	
What would you like to grow in or work on?	
What would you like to get out of therapy?	

Thank you for sharing. Your therapist will review this with you.

If you are in crisis, call or text 988, call 911, or go to the nearest emergency room. PeopleFirst is not an urgent care or emergency department.

Filling out a paper or PDF copy? Please return it to info@peoplefirstmn.com.