Client Questionnaire

Date______________

Name of Client____Date of Birth________________________

Name of Parent/Guardian____

Address _______________________________________ City _____________________ Zip ____________

Home Phone _________________________________ Cell Phone ________________________________

Date of Birth _____________________ Occupation ____

Place of Employment ______________________________ Referred by: ___________________________

Insurance Company ____Policy #_____________________

Marital Status: Single Married Divorced Separate Live-in Partner Widowed: How long: ______

Emergency Contact Person:

Name ____ Relationship ___________________________

Home Phone ___________________ Wk Phone ___________________ Cell Phone _________________

Name, age and relationship of persons living in your household:

____

____

Name and ages of children not living with you:

____

____

Have you seen a therapist/counselor/psychiatrist before? Yes No

When? ____

Who? ____

Reason for terminating: ____

Have you participated in a 12 step program? Yes No

Are you taking any medications at this time? Yes No

List medications: ____

____

Have you ever been hospitalized for psychiatric reasons? Yes No

Explain: ____

____

Have you ever been diagnosed with a mental health condition (i.e. Major Depression, Bipolar, Posttraumatic Stress Disorder, Anxiety, etc.) and if so by whom?

____

____

Have you ever thought about or attempted to kill yourself? ___________________________________

____

Have you ever been sexually abused? ____

____

Have you been a victim of a violent crime? ____

____

Have you been involved in domestic violence? ____

____

Have you ever put a baby up for adoption? ____

____

Name of Physician: ____________________________________ Phone: ________________________

Please list any medical conditions that you currently experiencing or being treated for:

____

____

____

____

Do you use any of the following alcohol, tobacco, prescription or illegal drugs? If so, please share how often: i.e. once a day, once a week? ____

____

____

Please check all symptoms/behaviors that you may have experiences in the past six months:

- ☐ Have too much energy
- ☐ Have crying spells
- ☐ Explosive temper
- ☐ Have fears or phobias
- ☐ Have homicidal thoughts
- ☐ Vomit to control your weight
- ☐ Eat too much
- ☐ Have panic attacks
- ☐ Have difficulty concentrating
- ☐ Feel needed and useful
- ☐ Have flashbacks of traumatic or painful events
- ☐ Feel that others would be better off if you were dead
- ☐ Find it difficult to make decisions
- ☐ Feel tired for no reason
- ☐ Sleep more than 8 hours
- ☐ Feel joyful
- ☐ Find it difficult to do the things you used to enjoy doing
- ☐ Feel down or blue
- ☐ Have trouble sleeping
- ☐ Isolate from others
- ☐ Feel that others control your actions
- ☐ Hear voices when no one is there
- ☐ Regularly Gamble
- ☐ Eat too little
- ☐ Have lost weight
- ☐ Feel hopeful
- ☐ Spend time with friends
- ☐ Heart racing when at rest
- ☐ Have nightmares
- ☐ Work more than 40 hours/week
- ☐ Have memory lapses

How do you cope with stress? ____

____

____

Has anyone in your family suffered from mental illness? If yes, whom and which mental illness?

____

____

Please state briefly what is troubling you now ____

____

____

What would you like to accomplish in therapy? ____

____

____

Is there anything additional you would like to share with me that you feel would assist in your treatment? ____

____