New Client Questionnaire:

(rev. 08/2016)

Client Name: _____ Date of Birth: ____/____/____

Date of First Session: ____/____/_____

What events or concerns brought you to my office? _____

_____

What goals would you like to accomplish? _____

_____

Are there any big changes/events you have been experiencing in your life? _____

_____

Current relationship status and previous marriages, divorces, or separations: _____

Length of marriages, divorces, separations: _____

Who else lives in your household? (Names, relationship to you, ages): _____

_____

Do you have other primary family members who do NOT live with you? (siblings, children) _____

_____

Number of close friends: _____

With whom do you spend most of your free time? Friends Family Alone

Religious/Spiritual orientation/identity: _____

Spiritual issues? Anger Grief Sadness Shame/Guilt Emptiness Forgiveness Other: ___

Family of Origin:

Father/Age/Relationship: _____

Father's vocational history: _____

Mother/Age/Relationship: _____

Mother's vocational history: _____

History and relationships with siblings and extended family: _____

_____

_____

Please describe your relationship with your own children: _____

_____

Significant events in your family history (divorce, death, incarceration, illness): _____

_____

_____

Any family history of substance abuse or mental health issues? Treatment or hospitalization? _____

_____

Who are your positive supportive relationships, currently? _____

_____

PHYSICAL HEALTH

Current symptoms: Asthma Cancer Diabetes Hypertension Arthritis

Insomnia Bleeding Allergies: _____

Chronic Illness: _____ Other: _____

Significant Health History: Injuries/Surgeries/Conditions: _____

_____

Date of last physical exam: _____ Physician: _____

Current level of physical activity: _____

Current level of healthy diet: _____

Any prenatal or developmental interruptions or problems? _____

Sexual identity: Hetero Gay Bisexual Queer Transgender
Male Female

Current medications (include OTCs):

Medication	Purpose	Dosage	Frequency

MENTAL HEALTH: Please provide details for any "yes" answers to the following questions:

Current mental health symptoms: _____

_____

Are you having any thoughts of suicide or homicide (last 30 days)? _____

_____

Have you had any thoughts of suicide or homicide in the past? _____

_____

Any attempts at suicide or self-harm? _____

Have you ever had a plan to commit suicide? _____

Have you experienced serious depression, sadness, or hopelessness? _____

_____

Have you experienced serious anxiety? _____

Do you see or hear things that others do not see or hear? _____

Have you experienced physical, sexual, psychological, spiritual, or emotional abuse/violence? _____

_____

Are there other traumatic events in your history? _____

_____

Do you now have trouble controlling violent behavior? _____

Have you ever had trouble controlling violent behavior? _____

Are you currently having any trouble performing activities of daily living? _____

_____

Please tell me about any previous mental health treatment or counseling? _____

_____

_____

Do you have any previous mental health diagnoses? _____

_____

ACADEMIC/WORK HISTORY:

Last grade completed: _____

Any learning difficulties? _____

Any Speech, language, hearing, visual functioning difficulties? _____

Future Plans: _____

Do you own a vehicle and driver's license? _____

Periods of unemployment? _____

Current job and employment information: _____

Obstacles to attainment of goals: _____

LEGAL HISTORY:

Offenses against you, the client? _____

History of legal issues, arrests, or convictions? _____

_____

Incarcerations? _____

Status Offenses? _____

Violence or Assault to others? _____

Other (please circle) : DUI Shoplifting Drug related Weapons Prostitution
Vandalism Burglary Robbery Sex Crimes Major Driving Violations Other: _____

SUBSTANCE ABUSE:

Major life events prior to problematic use? _____

Periods of Abstinence (when and why) _____

Last use? _____ Do you believe you have an addiction? _____

Influences on current use: _____

Experiences (circle please): Detox Overdose Sweats Shakes Convulsions
Seizures DTs Hallucinations Passing Out Hangovers Memory Loss
Blackouts Other: _____

Other addictive behaviors? (Gambling, sex, porn, video gaming,, eating, risk taking…) _____

_____

Consequences of Use: Legal relational family financial career other

_____

	First use	Last use	Frequency	Form	Reason	Life events
Tobacco						
Alcohol						
Marijuana						
Cocaine						
Meth/Amph						
Opiod						
Prescription						

Family Usage and treatment history: _____

_____

Client Treatment History: (Include education, evals, in- and out-patient treatment or counseling, and 12-step activity): _____

_____

Personal strengths and limitations: _____