



Confidential Care
New Client Questionnaire

If you are uncomfortable answering any questions, leave the space blank. You may also use the back of the form if needed. As with all your counseling related information, your privacy will be protected in accordance with HIPAA standards of confidentiality, with exceptions outlined in the Confidential Care 'Notice of Privacy Policy'.

Name: _____ Date: _____

A. PRIMARY CONCERN(S)

1. Please describe in your own words the primary issue(s) for which you are seeking counseling:

2. How long has the current issue existed/when did it begin? _____
(time-frame)

3. How frequently does it occur?

___ Rarely ___ Occasionally ___ Weekly ___ Daily ___ Most of the time ___ Continuously

4. Please describe your expectations of counseling

(In other words, how will things be different when counseling is successfully completed?)

5. **Present** psychological difficulties – please check any that apply to you at this time.

- | | |
|--|---|
| ___ Specific fears/Phobias (list): _____ | ___ _____ |
| ___ Generalized anxiety (across many situations) | ___ Problems sleeping through the night |
| ___ Panic attacks | ___ Nightmares |
| ___ Social Anxiety | ___ Flashbacks/Reoccurring disturbing memories |
| ___ Obsessive thinking or compulsive behaviors | ___ Suspiciousness of others |
| ___ Body-focused repetitive behaviors
(skin picking, hair pulling, nail biting, etc.) | ___ Hallucinations/Delusions |
| ___ Sadness or Depression | ___ Extreme mood changes of highs & lows |
| ___ Emotionally overwhelmed | ___ Restlessness or increase in energy level |
| ___ Frequent crying | ___ Racing thoughts |
| ___ Loss of energy | ___ Inability to cope with daily problems or stress |
| ___ Loss of pleasure in life | ___ Problems controlling temper |
| ___ Withdrawing from others, isolating | ___ Problems making or keeping friends |
| ___ Thoughts of suicide ___ Thoughts of homicide | ___ Relationship/Marriage problems |
| ___ Self-injurious/Self-harm behavior | ___ Problems with intimacy |
| ___ Fatigue/Tiredness during the day | ___ Problems with job ___ Problems in school |
| ___ Confused thinking or reduced ability to concentrate | ___ History of abuse (emotional, physical, sexual) |
| ___ Problems with eating | ___ Alcohol/Drug use |
| ___ Problems falling asleep | ___ Financial problems |
| | ___ Legal situation |

6. Please circle which **feelings** recently apply to you:

Depressed	Panicky	Stressed	Sad
Moody	Bored	Content	Concerned
Anxious	Tense	Restless	Jealous
Overwhelmed	Relaxed	Guilt	Numb
Mistrustful	Worthless	Uncertain	Unmotivated
Fearful	Hopeless	Hopeful	Optimistic

STRENGTHS: What are your major strengths, skills, talents, or what do you like about yourself?

MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT HISTORY

1. Have you received or participated in **Counseling**? ___No ___Yes (complete the following)

___Individual ___Couples/Marital ___Family ___Alcohol Abuse ___Substance Abuse

<u>Dates</u>	<u>Name of Agency/location</u>	<u>Name of Counselor</u>	<u>Purpose</u>	<u>Was it helpful?</u>
_____ to _____	_____	_____	_____	Y or N
_____ to _____	_____	_____	_____	Y or N
_____ to _____	_____	_____	_____	Y or N

2. Do you have a history of prior **Psychiatric Hospitalizations**? ___No ___Yes (complete the following)

<u>Dates</u>	<u>Name of Hospital/Location</u>	<u>Reason for Hospitalization</u>	<u>Was it helpful?</u>
_____ to _____	_____	_____	Y or N
_____ to _____	_____	_____	Y or N

3. Do you have a history of **Drug or Alcohol Treatment**? (Residential, IOP, etc.) ___No ___Yes

<u>Dates</u>	<u>Name of Treatment Center and Location</u>	<u>Reason for Treatment</u>	<u>Court Ordered?</u>	<u>Was it helpful?</u>
_____ to _____	_____	_____	_____	Y or N
_____ to _____	_____	_____	_____	Y or N

4. Do you have a history of **Self-Help/Support Group** participation? ___No ___Yes

<u>Dates</u>	<u>Name of Support Group</u>	<u>Reason for Participation</u>	<u>Was it helpful?</u>
_____ to _____	_____	_____	Y or N
_____ to _____	_____	_____	Y or N

MEDICATION HISTORY

1. Do you have a history of being prescribed medication(s) for mental health reasons? ___ No ___ Yes

2. What medications are you **CURRENTLY** prescribed for your mental and physical health?

Medication	Taken for	Date started	Dosage	Frequency	Prescribed by:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

3. Current over-the-counter medications (include vitamins, herbal remedies, and supplements): _____

4. Please list any other **PREVIOUSLY** prescribed mental health medication trials below: (note any side effects)

Medication	Taken for	Dates	Reason for stopping	Prescribed by:
_____	_____	_____ to _____	_____	_____
_____	_____	_____ to _____	_____	_____
_____	_____	_____ to _____	_____	_____
_____	_____	_____ to _____	_____	_____
_____	_____	_____ to _____	_____	_____

5. Please list Medication allergies or reactions.

<u>Name of Medication</u>	<u>Reaction</u>	<u>Name of Medication</u>	<u>Reaction</u>
_____	_____	_____	_____
_____	_____	_____	_____

GENERAL PHYSICAL HEALTH

1. How would you rate your current physical health? ___ Excellent ___ Good ___ Fair ___ Poor

2. Primary Care Provider's name/address/phone #: _____

3. When was your last physical exam? _____ any relevant findings? _____

4. Are you currently receiving care from other doctors, chiropractors, or other healthcare professionals?

<u>Provider's name</u>	<u>Condition that they are treating you for</u>
_____	_____
_____	_____

5. Describe any **medical conditions** (hypertension, diabetes, etc.) that you have been diagnosed as having and any medical procedures you have had (**surgeries**, etc. & list possible date/year).

SUBSTANCE ABUSE HISTORY

	Amount	Frequency	Duration	First use	Last use	Comments
<input type="checkbox"/> Alcohol	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Amphetamines	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Barbiturates	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Benzodiazepines	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Caffeine	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Cocaine/Crack	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Ecstasy	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hallucinogens	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Heroin	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Inhalants	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Marijuana	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Opiate/pain Medication	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Tobacco	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Tranquilizers	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Other:	_____	_____	_____	_____	_____	_____

1. Do you feel that your use of alcohol or drugs has caused a problem for you? _____ No _____ Yes
2. Have you tried to cut down or quit using or drinking alcohol? _____ No _____ Yes
3. Does anyone close to you (family member, co-worker, friend) feel that your use of alcohol or drugs is a problem? _____ No _____ Yes

CONSEQUENCES OF SUBSTANCE USE

_____ No Consequences	_____ Problems with Money
_____ Increased Tolerance	_____ Job Loss or Problems at Work/School
_____ Seizures	_____ Using or Consuming more than Intended
_____ Blackouts	_____ DUI
_____ Effects on Physical Health	_____ Arrests
_____ Relationship Conflicts	_____ Withdrawal Symptoms (shakes, sweating, nausea, etc.)
_____ Unintentional Overdose	_____ Other: _____

STRESSORS

In the last year, have there been any major life changes like marriage, divorce, death of a family member or close friend, illness or injury, or a change in job situation? _____ No _____ Yes

What stressors may have contributed to your current issues and clinical symptoms?

1. Primary relationship problems: [] none [] mild [] moderate [] severe
(spouse or parent/child/sibling)
2. Persistent Relationship Problems, non-primary: [] none [] mild [] moderate [] severe
(difficulties with other family members, conflict and loss of friends, difficulties with coworkers)
3. Occupational problems: [] none [] mild [] moderate [] severe
(lateness, absences, problems with boss or co-workers)
4. Academic problems: [] none [] mild [] moderate [] severe
(poor grades, inability to retain information, unable to meet deadlines)
5. Financial problems: [] none [] mild [] moderate [] severe
6. Health problems: [] none [] mild [] moderate [] severe
(physical incapacitation, chronic pain, or chronic illness)
7. Legal problems: [] none [] mild [] moderate [] severe
8. Housing problems: [] none [] mild [] moderate [] severe
9. Other: _____ [] none [] mild [] moderate [] severe

LEGAL HISTORY

1. Have you ever been arrested or convicted of a misdemeanor or felony? _____ No _____ Yes

If yes, please explain: _____

2. Are you currently involved in any divorce or child custody proceedings? _____ No _____ Yes

If yes, please explain: _____

3. Are you currently on probation, parole, house arrest, electronic monitoring, or are charges pending on any criminal matter? _____ No _____ Yes

If yes, please explain: _____

MILITARY HISTORY

1. Have you ever served in the military? _____ Yes/Branch _____ _____ No/(Skip to next section)

2. Where you personally involved in combat? _____ No _____ Yes: Where/date(s)? _____

3. Have you ever been discharge on an 'other than honorable' basis? If yes, please note type of discharge:

4. What was the highest rank you had attained? _____ Military discharge date: _____

5. How long did you serve in the military, on active duty? (Include National Guard and Reserves) _____

TRAUMA OR EXPOSURE TO TRAUMA

Have you as a child, adolescent, or adult:

1. ever been physically hurt or threatened by another? ___ No ___ Yes
2. been raped or had sex against your will? ___ No ___ Yes
3. lived through a natural disaster? ___ No ___ Yes
4. a history of neglect, verbal or emotional abuse ? ___ No ___ Yes
5. been a combat veteran or experienced an act of terrorism? ___ No ___ Yes
6. been in a severe accident, or been close to death from any cause? ___ No ___ Yes
7. witnessed death or violence or the threat of violence to someone else? ___ No ___ Yes
8. been a victim of a crime? ___ No ___ Yes

If you've answered 'yes' to any of the above questions, please describe: _____

RISK ASSESSMENT

1. Do you have **current** thoughts of harming yourself? ___ YES ___ NO
2. Do you have a plan for how you would harm yourself? ___ YES ___ NO
3. Have you attempted to harm yourself in the **past**? ___ YES ___ NO
4. Have any relatives committed suicide? ___ YES ___ NO
5. Do you have **current** thoughts of harming someone else? ___ YES ___ NO
6. Have you assaulted or threatened anyone recently? ___ YES ___ NO
7. Have you ever been in trouble because of your temper/violence? ___ YES ___ NO
8. Does drinking/drugging ever lead you to become violent? ___ YES ___ NO
9. Do you own a gun or a lethal weapon? ___ YES ___ NO
10. Have you ever considered or planned harming yourself or others with this gun or other lethal weapon? ___ YES ___ NO

If marked 'YES ' to any of the questions above, please explain in details: _____

DEVELOPMENTAL HISTORY

1. Are you aware of any physical/mental/environmental issues during the time your birth mother was pregnant with you? ___ No ___ Yes If yes, explain: _____

2. Are you aware of any complications related to your birth? ___ No ___ Yes

If yes, please explain: _____

3. Did you have any difficulties reaching any developmental milestones? ___ No ___ Yes
(walking, talking, reading, toileting, sleeping alone, being away from parents, or socializing with others)

If yes, please explain: _____

4. Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times? ___ Yes ___ No

5. Are you satisfied at where you are in your life? ___ Yes ___ No

If not, where would you like to be? _____

EDUCATIONAL HISTORY

1. Please indicate your highest level of education completed: _____
2. How would you rate your intellectual ability?
 Below Average Average Above Average Superior/Gifted
3. In general, what grades did you make in school?
 Mostly A's Mostly A's/ B's Mostly C's Many D's/F's
4. Any problems with learning, attention, or behavior in school? No Yes
If yes, please describe: _____

5. Which of the following best describes problems you may have had in school?
 Fighting Detentions Expulsions Suspensions Class failures
 Repetition of grades None of these
6. When attending school were you in: Regular classes Home schooled Special Ed.
 Advanced classes Placed in alternative school Speech classes

FAMILY OF ORIGIN

1. Were you adopted? No Yes: If yes, at what age were you adopted? _____
2. Where were you born and raised? _____
3. Who primarily raised you? _____
4. Were your parents married? No Yes
5. Did your parents' divorce/separate? No Yes If yes, how old were you? _____
6. What was your father's occupation? _____
7. What was your mother's occupation? _____
8. How many brothers and sisters do you have? Brothers: _____ Half-brothers: _____ Step-brothers: _____
Sisters: _____ Half-sisters: _____ Step-sisters: _____
9. What was your order of birth? Only child Youngest Middle Oldest
10. What was your family's economic status during your childhood and adolescence?
 Poverty level (on welfare) Working Class Middle Class Upper Middle Class Wealthy
11. How would you describe your childhood atmosphere?
 Normal Supportive Traditional Parental violence Parental arguing/fighting
 Poor Frequent moving Neglectful Abusive No parental supervision
12. Did you experience any stressors or issues as a child or adolescent? No problems
STRESSORS:
 Death of friend or family member Ill health of family member Physical/medical illness (self)
 Financial problems Abuse in Family Addiction in Family Violence in Family
 Frequent moves Parental divorce Victim of bullying Other: _____
ISSUES:
 Running away from home Bedwetting Fighting Stealing Vandalism
 Anxiety Depression Socially inept Insecure Nightmares
 Other: _____

FAMILY MEDICAL, PSYCHIATRIC, SUBSTANCE USE, SUICIDE & VIOLENCE HISTORY

* Biological Relatives only	Living (Y/N)	Quality of Rel.	Age	Family Medical, Psychiatric, Substance Use, Suicide & Violence History
Example Mother	Y	2	53	Hypertension, diabetes, depression with 1 suicide attempt, alcoholic
Mother				
Maternal Grandmother				
Maternal Grandfather				
Father				
Paternal Grandmother				
Paternal Grandfather				
Child _____ or Sibling _____ M or F				
Child _____ or Sibling _____ M or F				
Child _____ or Sibling _____ M or F				
Child _____ or Sibling _____ M or F				
Child _____ or Sibling _____ M or F				
Child _____ or Sibling _____ M or F				
<p>Quality of Relationship - under the 'Quality of Rel.' column note the quality of your relationship with this biological relative by selecting one of the following numbers: 1= Good 2=Fair 3=Poor 4=Distant 5=Non-existent</p>				

Please use the back of this sheet to add any additional 'biological' family members that should be included in your family medical, psychiatric, substance abuse, suicide, and violence history.

SOCIAL SUPPORT & SELF-CARE INFORMATION

1. Which options below best describes your social situation?

____ Supportive social network ____ Few friends ____ Substance-use based friends ____ No friends
____ Distant from family of origin ____ Family conflict ____ Other: _____

2. Describe your hobbies/interests: _____

3. What activities do you enjoy?

Alone: _____ with Family/Friends: _____

4. What is a usual day like for you and how has this been changed by your current symptoms?

5. How do you rate your overall nutritional content of your current diet?

____ Excellent ____ Very Good ____ Satisfactory ____ Poor ____ Unsure

Do you feel you need to lose or gain weight? ____ No ____ Yes: _____

6. Do you exercise regularly? ____ No ____ Yes

If yes, what type of exercise do you enjoy or engage in, how often, and for how long?

Type _____ minutes/day _____ days/week _____

Type _____ minutes/day _____ days/week _____

CULTURE AND SPIRITUALITY

1. To which culture or ethnic group do you belong? _____

If you are experiencing any difficulties due to cultural or ethnic issues, please describe: _____

2. What Religion/Spirituality beliefs do you identify with, if any? _____

3. How would you describe the importance and impact that spirituality/Religion has on you now?

____ No influence whatsoever ____ Minimal influence ____ Moderate influence ____ Central part of my life

RELATIONSHIP HISTORY AND CURRENT FAMILY

1. Are you currently:
 Single, never married Married Divorced Separated or divorce in process Widowed
How long? _____
2. If not married, are you currently in a relationship? No Yes If yes, how long? _____
3. Are you sexually active? No Yes
4. How would you identify your sexual orientation?
 Heterosexual/straight Homosexual/gay/lesbian Bisexual Prefer not to answer
5. What is your spouse or significant other's occupation? _____
6. What is the satisfaction level of your intimate relationship?
 Very satisfied Satisfied Somewhat satisfied Dissatisfied Not applicable
If less than satisfied, what would you like to see improved in your current relationship? _____

7. Have you had any prior marriages? No Yes
If Yes, how many? _____ How long? _____
8. Do you have any children? No Yes If yes, please complete the following:
- | <u>Result of Current or Past Relationship?</u> | <u>First Name</u> | <u>Age</u> | <u>Gender</u> | <u>Quality of Relationship</u> |
|--|-------------------|------------|---------------|--------------------------------|
|--|-------------------|------------|---------------|--------------------------------|
9. What is your current living situation? Rent (apartment/house) Own (house/condo)
 Homeless Campus Other: _____
10. Are you satisfied with your current living environment/arrangement? Yes No
If no, why not? _____
11. Who currently lives with you?
 Lives alone Roommates Partner/Spouse Parent(s) Sibling(s) Children
 Other(s): _____

FINANCIAL AND EMPLOYMENT HISTORY

1. What is your family's primary source of income?

My earnings Partner's earnings Both of our earnings Relatives support us
 Disability Retirement Government Assistance Other: _____

2. What is your current annual family income?

Less than 11,000 11,000 – 25,999 26,000 – 75,999 76,000 – 100,000 Over 100,000

3. What is your current occupational status? Full-time Part-time Seasonal/Temp Homemaker

Unemployed (not seeking work) Unemployed (looking for work) Retired Disabled

Full-time Student Part-time Student

4. If not currently employed, when did you last work outside of your home? _____

What type of work did you do? _____ How long did you work at that job? _____

5. If employed, what type of work do you do? _____

How long have you been working at your current primary job? _____

In general, how much do you enjoy your work? N/A It's enjoyable It's a job I don't enjoy it

6. What other types of jobs have you held in the past? _____

7. Do you currently have, or have you in the past, any significant problems at work? No Yes:

FOCUS OF TREATMENT

1. Summarize your goals for counseling/therapy: (What are you willing to work on?)

2. What expectations do you have for counseling/therapy?

3. Name 5 things you would like to change about yourself:

1.

2.

3.

4.

5.

Thank you for taking the time to answer these questions.

We hope to help you achieve your goals in therapy as you begin your journey to a healthier and happier tomorrow.

CONFIDENTIAL CARE