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)
_____Panic attacks
_____Social Anxiety
_____Obsessive thinking or compulsive behaviors
_____Body-focused repetitive behaviors
(skin picking, hair pulling, nail biting, etc.)
_____Sadness or Depression
_____Emotionally overwhelmed
_____Frequent crying
_____Loss of energy
_____Loss of pleasure in life
_____Withdrawing from others, isolating
_____Thoughts of suicide _____Thoughts of homicide
_____Self-injurious/Self-harm behavior
_____Fatigue/Tiredness during the day
_____Confused thinking or reduced ability to concentrate
_____Problems with eating
_____Problems falling asleep

_____
_____Problems sleeping through the night
_____Nightmares
_____Flashbacks/Reoccurring disturbing memories
_____Suspiciousness of others
_____Hallucinations/Delusions
_____Extreme mood changes of highs & lows
_____Restlessness or increase in energy level
_____Racing thoughts
_____Inability to cope with daily problems or stress
_____Problems controlling temper
_____Problems making or keeping friends
_____Relationship/Marriage problems
_____Problems with intimacy
_____Problems with job _____Problems in school
_____History of abuse (emotional, physical, sexual)
_____Alcohol/Drug use
_____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

Dates	Name of Agency/location	Name of Counselor	Purpose	Was it helpful?
_____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)

Dates	Name of Hospital/Location	Reason for Hospitalization	Was it helpful?
_____to_____	_____	_____	Y or N
_____to_____	_____	_____	Y or N

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

Dates	Name of Treatment Center and Location	Reason for Treatment	Court Ordered?	Was it helpful?
_____to_____	_____	_____	_____	Y or N
_____to_____	_____	_____	_____	Y or N

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

Dates	Name of Support Group	Reason for Participation	Was it helpful?
_____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.

Name of Medication	Reaction	Name of Medication	Reaction

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?

Provider's name	Condition that they are treating you for

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
[ ] Alcohol						
[ ] Amphetamines						
[ ] Barbiturates						
[ ] Benzodiazepines						
[ ] Caffeine						
[ ] Cocaine/Crack						
[ ] Ecstasy						
[ ] Hallucinogens						
[ ] Heroin						
[ ] Inhalants						
[ ] Marijuana						
[ ] Opiate/pain Medication						
[ ] Tobacco						
[ ] Tranquilizers						
[ ] 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
_____Increased Tolerance
_____Seizures
_____Blackouts
_____Effects on Physical Health
_____Relationship Conflicts
_____Unintentional Overdose
_____Problems with Money
_____Job Loss or Problems at Work/School
_____Using or Consuming more than Intended
_____DUI
_____Arrests
_____Withdrawal Symptoms (shakes, sweating, nausea, etc.)
_____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. Family 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				

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

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:

Result of Current or Past Relationship?	First Name	Age	Gender	Quality of Relationship

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 stats? ____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 you goals for counseling/therapy: (What are you willing to work on?)

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

3. Name 5 thing 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.

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