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Client Questionnaire

Please fill in the information below and bring it with you to your first session.

Please note: information provided on this form is protected as confidential information.

Name: ____

Date: ____

Date of Birth___________ Age: _______ Gender: _________________

Parent/ Legal Guardian (if under 18) _________________________

Address:____

Home Phone: ___________________________________ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: __________________________ May we leave a message? □ Yes □ No
Email: ____ May we leave a message? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed

Emergency Contact (name, Relation, Phone number)

____

(By providing this information you are authorizing therapist to contact this person in the case of an emergency)

Referred By (if any):

____

<u>General and Mental Health Information</u>

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner:

____

Are you currently taking any prescription medication? □ Yes □ No If yes, please list:

____
____

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Have you ever been prescribed psychiatric medication? □ Yes □ No If yes, please list and provide dates:

____

____

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

____

____

2. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

____

3. How many times per week do you generally exercise?
__________________________________ What types of exercise do you participate in?
____

4. Please list any difficulties you experience with your appetite or eating problems:

____

____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?

____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this?

____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe:

____

8. Do you drink alcohol more than once a week? □ No □ Yes

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9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long?

____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

____

11. What significant life changes or stressful events have you experienced recently?

____

____

PLEASE CHECK ALL THAT APPLY – Have you had, or do you have a history of, any of the following?

□ Depression
□ Anxiety
□ Managing Stress
□ Loss of Loved One
□ Problems at Work
□ Relationship Issues
□ Sexuality/Sexual Issues
□ Family Conflict
□ Behavioral Problems
□ Trauma
□ Hallucinations
□ Other ____________

□ Problems Coping
□ Loneliness
□ Abuse
□ Problems at School
□ Financial Problems
□ Legal Matter
□ Lack of Friends
□ Suicidal Thoughts or Attempts
□ Homicidal Thoughts or Attempts
□ Drugs/Alcohol
□ Paranoid Thoughts

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Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

List Family Member

Alcohol/Substance Abuse yes / no ________________________ Anxiety yes / no ________________________ Depression yes / no ________________________ Domestic Violence yes / no ________________________ Eating Disorders yes / no ________________________ Obesity yes / no ________________________ Obsessive Compulsive Behavior yes / no ________________________ Schizophrenia yes / no ________________________ Suicide Attempts yes / no ________________________

Additional Information

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

____

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

____

____

3. What do you consider to be some of your strengths?

____

____

4. What do you consider to be some of your weaknesses?

____

____

5. What would you like to accomplish out of your time in therapy?

____

____