Adult Pre-Treatment Questionnaire

Clarity Counseling Associates

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Name: _____ Date: _____

Partner/Marital Status:

__ Never Married
__ Living together
__ Married
__ Separated
__ Divorced
__ Widowed

Current Employment:

__ Full-time
__ Part-time
__ Unemployed
__ Laid off
__ Student
__ Disabled
__ Retired

Education

__ Grade 8 or less
__ Some high school
__ High school graduate
__ Some college
__ College graduate/
Degree: _____
__ Graduate School/
Degree: _____

Children in the Family __ None

Name	**Sex *(circle)***	**Age**	**Primarily living in your home?**
_____	Male/ Female	____	Yes No
_____	Male /Female	____	Yes No
_____	Male /Female	____	Yes No
_____	Male /Female	____	Yes No
_____	Male /Female	____	Yes No
_____	Male / Female	____	Yes No

Are you currently under a physician's care? *(circle one)* Yes No

If yes, name of physician and reason: _____

_____

_____

List any current medications, dosage, and reason:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you received prior counseling or related services? *(Circle one)* Yes No

****

Name of therapist: _____Where: _____

Length of treatment: _____ (months/years) How long ago? _____ (months/years)

Problem(s) treated: _____

Outcome: *(circle one):*

1 2 3 4 5 6 7 8 9 10

Much worse *Stayed the same* *Much better*

****

Name of therapist: _____Where: _____

Length of treatment: _____ (months/years) How long ago? _____ (months/years)

Problem(s) treated: _____

_____

Outcome: *(circle one):*

1 2 3 4 5 6 7 8 9 10

Much worse *Stayed the same* *Much better*

Please check any of the reasons listed below which led you to seek treatment, **choosing up to the 3 most important:**

__ Depression or anxiety
__ Worry about drinking or drug use
__ Communication problems
__ Desire to improve sexual relations
__ Parent/child conflict
__ Sexual orientation questions
__ Problematic or too much anger
__ Social isolation or other social challenges
__ Trouble controlling impulses
__ Abuse *(physical/sexual/emotional/verbal)*
__ Trauma (*other than abuse-i.e. natural disaster, accident, crime witness, etc.)*
__ Thinking of harming self or others
__ Learning/memory problems
__ Difficulty with loss or death
__ Want relationship to be better
__ Divorce counseling
__ Individual counseling
__ Pre-marital counseling
__ Family counseling
__ Couples counseling
__ Partner/family member wanted me to come
Other: _____

Regarding the **most important** reason that brings you here, please rate the following:

Issue 1 _____

How often does issue happen?

__ Happens rarely
__ Happens 1-2 times a week
__ Happens 3-5 times a week
__ Happens daily
__ Happens several times a day

How does it affect your functioning?

__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I need and want to do
__ I can only do some of the things I need and want to do
__ I can barely do the things I need to do
__ I am unable to work or care for myself

Issue 2 _____

How often does issue happen?

__ Happens rarely
__ Happens 1-2 times a week
__ Happens 3-5 times a week
__ Happens daily
__ Happens several times a day

How does it affect your functioning?

__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I need and want to do
__ I can only do some of the things I need and want to do
__ I can barely do the things I need to do
__ I am unable to work or care for myself

Issue 3 _____

How often does issue happen?

__ Happens rarely
__ Happens 1-2 times a week
__ Happens 3-5 times a week
__ Happens daily
__ Happens several times a day

How does it affect your functioning?

__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I need and want to do
__ I can only do some of the things I need and want to do
__ I can barely do the things I need to do
__ I am unable to work or care for myself

What questions do you hope will be answered?

_____

_____

_____

_____

_____

_____

Is there anything else you want your therapist to know?

_____

_____

_____

_____

_____

_____

Person to contact in case of emergency: _____ Relationship: _____

Address: _____

Phone numbers: Home: _____Work: _____Cell: _____

Signature: _____ Date: _____