New Client Questionnaire

Ann-Marie Bowen, M.A., Licensed Professional Counselor

Name: _____ Date: _____
Gender: _____ Age: _____

The following assessment will assist me in helping you by providing me with a thorough understanding of you and your specific needs. Please answer the following questions as fully and honestly as possible, based on your level of comfort. If you have any questions or concerns, please ask.

What are the main problems or events that have led you to seek counseling now?

_____
_____
_____

When did these problems develop? _____
_____

Current problems (please circle all that are applicable):

Marital/Relational
Health Issues
Grief/Loss
Job/Career issues
Financial struggles
Parent/Child issues
Past Issues (abuse, guilt, family of origin issues)
Spiritual struggles
Other: _____

Symptoms (please circle all that apply):

Sleep Problems
Decreased Energy/Fatigue
Difficulty Concentrating
Decreased Motivation
Appetite Changes
Depressed Mood
Anxiety/Worry/Panic
Stress
Loneliness
Anger Problems
Mood Swings
Addiction Issues (Alcohol, Drug, or other)
Sexual Concerns
Disturbing Thoughts
Thoughts of Death
Other: _____

Strengths/Weaknesses:

What are your greatest strengths? _____
_____
_____

What are your greatest weaknesses? _____
_____
_____

On a scale of 1-5 (5 is high), how satisfied are you with yourself? _____
On a scale of 1-5, how satisfied are you with your current life? _____

Suicide/Homicide Assessment

Have you ever attempted to commit suicide or homicide in the past? _____
Please explain: _____
Is there are history of suicide in your family? _____
Have you ever inflicted wounds on yourself? _____
Are you presently suicidal or homicidal? _____
Do you have other risk taking behaviors that you engage in? _____

Psychiatric/Medical History:

Please list any current or previous experience seeing a psychiatrist, seeing a counselor or psychologist, or being hospitalized for a mental health or addiction issue:

Date (Approximate)	Name of Provider/Facility	Reason for Treatment	Outcome (what helped and why)

How would you describe your current condition of health? _____
_____
Do you have any disabilities or health problems? _____
_____
Please list any medication for anxiety, depression, sleep, etc. you currently take or have taken in the past: _____
_____
Please list any family history of addiction or emotional struggles: _____
_____
Have you ever had an abortion (for males, has a child of yours ever been aborted)? _____
If yes, date(s): _____

Substance Use History:

Do you use any of the following?

Substance:	Yes	No	Amount	Frequency:	Date Last Used:
Tobacco	___	___	_____	_____	_____
Caffeine	___	___	_____	_____	_____
Alcohol	___	___	_____	_____	_____
Marijuana	___	___	_____	_____	_____
Cocaine	___	___	_____	_____	_____
Amphetamines	___	___	_____	_____	_____
LSD	___	___	_____	_____	_____
Heroin	___	___	_____	_____	_____
Pain Killers	___	___	_____	_____	_____
IV Drug Use	___	___	_____	_____	_____
Other: _____	___	___	_____	_____	_____

Has there been a recent increase in your use of any of these substances? _____
Do you, your family, or your friends see your current usage as a problem? _____

Nutrition:

Do you have balanced, healthy eating patterns? _____
Do you have concerns about your weight and shape? _____
Do you tend to eat out of depression, boredom, or anger? _____
Do you ever binge eat or fear losing control of your eating? _____
Do you ever self-induce vomiting? _____
Do you use laxatives, diuretics, or diet medication for weight control? _____
Do you or others believe you exercise excessively? _____

Legal History:

Do you have any history with the legal system including charges as a minor, present charges, arrests, bankruptcy, civil suits, probation, parole, or child custody problems?
Please explain briefly. _____
_____
_____

Military History:

If applicable, please list branch, dates, and duties. _____
_____
_____

Educational History:

What was school like for you? _____
_____
Highest level achieved: _____
What type of grades did you make? _____

Were you ever diagnosed with a learning disability or ADHD or do you suspect you should have been diagnosed? _____

_____

Are you currently in school? _____

Work History:

What is your current job/career? _____

_____

What do you like/dislike about your job? _____

_____

_____

How do you get along with authority figures and co-workers? _____

_____

Have you ever been fired or laid off? _____

Describe your current level of job performance. _____

_____

How many jobs have you had in the last 5 years? _____

Financial:

Briefly describe your financial situation: _____

_____

Developmental History:

Where were you born and raised? _____

Circle words you would use to describe your childhood:

Traumatic Painful Uneventful Good/Happy Other: _____

What were you like as a child (include friends, school, hobbies, personality)? _____

_____

_____

What was your birth order? ____ of ____ children.

Who primarily raised you? _____

What is the marital status of your parents? _____

List members of your childhood family and describe your relationship with each one:

Name	Relationship	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Were there any unusual or traumatic experiences for you as a child?

Age	Event
_____	_____
_____	_____
_____	_____

Who or what would you consider positive influences on your development? _____
_____
Have you ever been the recipient of unwanted sexual acts? _____
_____
Have you ever been the victim of abuse, neglect, or violence? _____
_____
Have you ever been the perpetrator of abuse toward another person? _____
_____
What is your sexual orientation? _____

Current Living Arrangements:

Is your current living situation satisfactory or unsatisfactory? _____
Where do you live? _____ How long there? _____
With whom do you live? _____

Marital History (if applicable):

If currently married, how long have you been married? _____
Name and age of spouse: _____
What is your spouse's occupation? _____
What is your perception of your current marriage (communication, strengths, weaknesses, etc.)? _____
_____
Please list dates of any previous marriages: _____
_____

Children (if applicable):

Please list names and ages of children and comment of your relationship with each one.

Name	Age	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social Relationships and Support System:

Who can you rely on for support? _____
_____
Do you have close friendships? _____ Please describe: _____
_____
What are your hobbies or leisure activities? _____
_____
Would it be beneficial for your spouse (if applicable) or any other family members to be involved in your treatment? ____ Please explain: _____
_____
What is your family's perception of your difficulties? _____
_____

Religious/Cultural Factors:

What is your religious background? _____
What is your cultural background? _____
Describe the influence of religious and cultural factors in your home, both in the past and currently: _____
_____
_____
Do you currently attend church, synagogue, mosque, or other place of worship? _____
If yes, where? _____
What does God seem like to you? _____
Describe your relationship with God: _____
_____
What do you consider the role of God in your recovery? _____
_____
Describe your level of comfort with the inclusion of such things as prayer and scripture in your counseling sessions: _____
_____

Miscellaneous:

Is there anything else that it would be helpful for me to know about you? _____
_____
_____

Goals and Objectives:

What would you like to gain from your counseling experience? What would you like to be different when you are finished with your treatment? Please be as detailed as possible. You may continue on the back if necessary.

1. _____
   _____
2. _____
   _____
3. _____
   _____

Thank you so much for taking the time to fill out this lengthy questionnaire. It can be difficult to be vulnerable with the details of your life, but I promise that the time you took to fill this out will be extremely helpful in assisting me in our work together. I look forward to working with you!

Signature: _____ Date: _____

Counselor: _____ Date: _____
Ann-Marie Bowen, M.A., L.P.C.