CLIENT QUESTIONNAIRE

Name_____ S.S.#_____

Name of Parent / Guardian(s) (if applicable): _____

Address_____
Street State Zip

Date of Birth and Age _____

Marital Status_____ Gender_____ Ethnicity _____

Phone: Home_____ Cell_____ Work_____

May we contact you at home?_____ at work? _____ Email_____

Emergency contact _____ Relationship_____ Phone _____

Who referred you?_____

MEDICAL

Name of physician:_____ Date of last exam:_____

List major health problems &/or persistent health concerns: _____

_____

Current medications and dosage: _____

_____

Surgeries? Please list what & when: _____

Have you had previous psychological or psychiatric treatment? ☐ Yes ☐ No If yes, was it beneficial? ☐ Yes ☐ No

What would you change? _____

List dates of any psychiatric hospitalizations: _____

Reason(s) for seeking counseling / Major stressors: _____

_____

In the past year, list major changes to you/your family experienced (financial, medical, etc.):_____

_____

Check any of the following that apply to you:

____Sleeplessness	____Isolating	____Anxiety	____Too much energy
____Sleeping too much	____Depression	____Panic Attacks	____Temper Outbursts
____Crying	____Feeling worthless	____Absences (Work/School)	____ Aggressive behavior
____Sadness	_____Feeling hopeless	_____Compulsions	_____Impulsive reactions
____ Grief	_____Death wishes	_____Obsessions	_____Take too many risks
_____Too little energy	_____Suicidal thoughts	_____Appetite problems	_____Employment problems
_____Low motivation	_____Worrying	_____Eating problems	_____Drink too much alcohol
_____Memory problems	_____Nervousness	_____Relationship	_____Illegal drugs
_____Concentration problems	_____Fears	_____Sexual problems	_____Neglected hygiene

_____Other: _____

Check any of the following that often apply to you

_____Angry	_____Fearful	_____Happy	_____Hopeful	_____Bored
_____Optimistic	_____Annoyed	_____Panicked	_____Conflicted	_____ Helpless
_____Restless	_____Tense	_____Sad	_____Energetic	_____Shameful
_____Relaxed	_____Lonely	_____Shy	_____Envious	_____Regretful
_____Jealous	_____Contented	_____Anxious	_____Unassertive	_____Guilty
_____Hopeless	_____Unhappy	_____Excited	_____Other:_____	

Are you having any problems with your sleep habits? ☐ Yes ☐ No

If yes, check all that apply: ( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep ( ) Disturbing dreams

How many times per week do you exercise? _____

Describe types, duration, and frequency of exercise: _____

Women: Do your menstrual periods affect your moods? ☐ Yes ☐ No Date of last period:_____

Are you having difficulty with appetite or eating habits? ☐ Yes ☐ No

If yes, check all that apply: ( ) Eating less ( ) Eating more ( ) Binging ( ) Restricting

Have you experienced significant weight change in the last 2 months? ☐ Yes ☐ No If yes, *gain or loss*

Do you regularly use alcohol? ☐ Yes ☐ No If yes, list frequency:_____ amount:_____

Recreational drug use? ( ) Daily ( ) Weekly ( ) Monthly ( ) Rarely ( ) Never

Type(s): _____

Do you have a history of substance abuse? ☐ No ☐ Yes, please describe and list any treatment you have received:

_____

Do you ever think about killing yourself? ☐ No ☐ Yes, explain:_____

Have you ever attempted suicide? ☐ No ☐ Yes, describe:_____

Have you ever deliberately hurt yourself? ☐ No ☐ Yes, describe: _____

Have you ever seen or heard things that were not there? ☐ No ☐ Yes, describe: _____

Have you ever thought that others were trying to harm you? ☐ No ☐ Yes, describe: _____

Are you bothered by thought that occurs over and over again? ☐ No ☐ Yes, describe:_____

_____

Have you ever had any eating disorder problems? ☐ No ☐ Yes, describe:

_____

Do you have trouble relaxing or enjoying weekends and vacations? ☐ No ☐ Yes, describe:_____

FAMILY HISTORY

Where were you born?_____ raised?_____

Please describe anything unusual about your early development or mother's pregnancy with you:_____

_____

Father's age:_____ Occupation:_____ Health:_____

If deceased, age at time of death:_____ Cause of death:_____ Your age at the time:_____

Mother's age:_____ Occupation:_____ Health:_____

If deceased, age at time of death:_____ Cause of death:_____ Your age at the time:_____

Please list sibling(s)' names and ages and describe your relationship(s):_____

_____

_____

Were you brought up by your parents? ☐ Yes ☐ No If no, who raised you?_____

Describe your relationship(s) with each parent/guardian: _____

_____

_____

How was your childhood? _____

_____

If your parents divorced how old were you?_____ If one or both remarried how old were you? _____

Describe your relationship with your stepparent(s): _____

Is there any history of psychiatric/psychological or substance use problems in your family history? ☐ Yes ☐ No

If yes, please describe: _____

Has anyone outside or inside your home abused you:

physically? ☐ Yes ☐ No verbally? ☐ Yes ☐ No sexually? ☐ Yes ☐ No emotionally? ☐ Yes ☐ No

Are you married? ☐ Yes ☐ No If yes, length of marriage:_____ Spouse's age: _____

Spouse's occupation:_____

Are you in a relationship? ☐ Yes ☐ No If yes, length of relationship: _____ Partner's age:_____

How satisfied are you with your marriage/relationship? *Very Dissatisfied 1 2 3 4 5 6 7 Very satisfied*

Are you divorced? ☐ Yes ☐ No If yes, when?_____ Years of marriage:_____

Are you widowed? ☐ Yes ☐ No If yes, cause of spouse's death_____

When?_____ Years of marriage:_____

Number of previous marriages and any significant details:_____

Please list child(ren)s' names and ages and describe your relationship(s):_____

_____

Please describe any special difficulties presented by your children:_____

_____

OCCUPATIONAL

Years of school completed_____ Highest Degree_____ Major_____

Are you currently employed? ☐ Yes ☐ No If yes, how long have you worked at your current job?_____

How satisfied are you with your work? *Very Dissatisfied 1 2 3 4 5 6 7 Very satisfied*

List jobs you've held in the past:_____

Please describe any work-related stressors:_____

Have you had any legal problems or involvement – describe what and when _____

STRENGTHS & INTERESTS

What are your strengths / What do you like about yourself? _____

What are your interests? _____

How you do you manage stress? _____

Do you have faith/spiritual interest? _____

What changes would you like to see in yourself? _____

What changes would you like to see in your family/couple? _____

What are your expectations or goals for counseling? _____

What else would you like me to know about you? _____