Date _______________

CHESTNUT PARK PROFESSIONALS, LLC
CLIENT QUESTIONNAIRE

Name______________________________ Social Security No._________________ DL#________________

Address ____
Street City State Zip P.O. Box

Phone: Home___________________________ Work ____________________ Cell___________________

Age___________ Birth date____________________ Marital Status _____________ Gender____________

Years of school completed ____ Highest degree ___________Major ____________________________________

May we contact you at home? _____ at work? ______ email? _____________________________________

May we leave you a message at home? _____ at work? _____

Who referred you? __________________________ May we send a letter thanking him/her? Yes ___ No ___

MEDICAL

Name of Physician _______________________________________ Date of last exam _________________

Major health problems____

Medications you are on____

Surgeries, with dates ____

INSURANCE

_________________________________ _________________________________ ________________

Insurance Policyholder's Name Employer Policy holder's birth date

__________________________________ ______________________________ ____________________

Insurance Company Policy holder's SSN Policy Number

Responsible party (if other than client) ____

Address ____

Name of person to be contacted in case of emergency ________________________ Ph # ______________

ASSIGNMENT OF BENEFITS: I request that payment of private insurance and/or government benefits for my treatment be made to Chestnut Park Professionals, LLC.

Signature of client or his/her representative_________________________________ Date _______________

CONSENT TO TREATMENT: I consent that I, or the person whom I represent, receive psychological treatment from Chestnut Park Professionals, LLC.

Signature of client or his/her representative _________________________________ Date ______________

Date ________________

Please answer the following questions. Your answers will help us help you. You may skip questions which you prefer not to answer.

Reason(s) for seeking psychological help: ____

____

Previous psychological or psychiatric treatment (please give reason and when) ________________________________

____

If you were hospitalized, when and where ____

Please list whatever is causing you stress ____

____

Check any of the following problems that apply to you:

__Sleeplessness	__Isolating	__Anxiety	__Too much energy
__Sleeping too much	__Depression	__Panic attacks	__ Temper outbursts
__Crying	__Feeling worthless	__Problem thoughts	__Aggressive behavior
__Sadness	__Feeling hopeless	__Compulsions	__Impulsive reactions
__Grief	__Death wishes	__Obsessions	__Take too many risks
__Too little energy	__Suicidal thoughts	__Appetite problems	__Can't keep a job
__Low motivation	__Worrying	__Eating problems	__Drink too much alcohol
__Memory problems	__Nervousness	__Relationship problems	__Take drugs illegally
__Concentration problems	__Fears	__Sexual problems	__Other ____________________

Check any of the following feelings that often apply to you:

____Angry	_____Fearful	_____Happy	_____Hopeful	_____Bored	_____Optimistic
____Annoyed	_____Panicky	_____Conflicted	_____Helpless	_____Restless	_____Tense
____Sad	_____Energetic	_____Shameful	_____Relaxed	_____Lonely	_____Shy
____Envious	_____Regretful	_____Jealous	_____Contented	_____Anxious	_____Unassertive
____Guilty	_____Hopeless	_____Unhappy	_____Excited	Other feelings______________________	

Describe any mood problems you have ____

____

For women: do your menstrual periods affect your moods? ______________________ Date of last period_________

Do you ever think about killing yourself? No ___Yes ___. If yes, describe ___________________________________

Have you ever attempted suicide? No ___Yes ___. If yes, describe ____

Have you ever deliberately hurt yourself? No ___Yes ___. If yes, describe ___________________________________

Have you seen or heard things that were not there? No ___Yes ___. If yes, describe _____________________________

Have you ever thought that others were trying to harm you? No ___Yes ___. If yes, describe _____________________

____

Date _______________

Are you bothered by thoughts that occur over and over again? No ___Yes __________________________________

Do you have trouble relaxing or enjoying weekends and vacations? No ___Yes ___. If yes, please explain _______

____

Have you had any eating disorder problems? No ___Yes ___. If yes, describe _______________________________

____

Do you drink alcohol? No ___Yes ___. If yes, how much and how often? __________________________________

Do you have any history of substance abuse? No ___Yes ___. If yes, please describe and list any S.A. treatment you have received____

FAMILY HISTORY

Where were you born and raised?____

Was there anything unusual about your early development? ____

Father's age:____ Occupation:_____________________________ Health:___________________ If deceased, give his age at time of death:______ Cause of death: _________________________________ Your age at the time?_____

Mother's age:____ Occupation:_____________________________Health:___________________If deceased, give her age at time of death:______ Cause of death: _________________________________ Your age at the time?_____

Siblings: Age(s) of brother(s):_____________________ Age(s) of sister(s):________________________________

Give significant details about siblings and describe how you get along with them_____________________________

____

Were you brought up by your parents? _____ If not, who raised you and between what years?___________________

Describe your relationship with each parent:____

____ How good was your childhood? ______________________

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

Describe your relationship(s) with stepparent(s) ____

Is there any history of substance abuse or psychiatric problems in your family history? No ___Yes ___. If yes, please describe: ____

Has anyone outside or inside your family abused you physically _____ verbally_____ or sexually _____?

Date ________________

Family

Are you married _____ Years of marriage _____ Spouse's age _____Spouse's occupation ______________________

On the scale below, please indicate how satisfied you are with your marriage:

Very dissatisfied 1 2 3 4 5 6 7 Very satisfied

Are you divorced_____ When ______Years of marriage _____ Ex-spouse's occupation ______________________

Are you widowed _____ Cause of spouse's death _______________________ When ______ Years of marriage _____

Number of previous marriages and any significant details ____

Names and ages of any children ____

Please describe any special problems presented by your children ____

____

OTHER

How long have your worked at your present job? ____yrs. How satisfied are you with your work? ________________

List jobs you held in the past ____

Describe any problems in your work relationships ____

Do you exercise regularly? ______ If yes, what type and how often____

Have you ever smoked? No ___Yes ___. If yes, when did you start _______ when did you last smoke _____________

Have you ever been in a fight? No ___Yes ___. If yes, how often do you get in fights? ____ Date of last fight _______

If you have had any legal problems, describe what and when__________ ____________________________________

How do you spend your free time? ____

____

Do you make friends easily? No ___Yes ___. Do you wish you had more friends? ______________________________

How do you calm yourself when stressed?____

____

List the persons who are available to you when you are in need of social support_______________________________

____

Do you have an active faith life? ______ If you attend church, where and how often? ___________________________

Additional relevant information ____

____

____