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Client Information Questionnaire

The information asked for below is to help me understand you and your concerns. All information given by you is confidential unless released by written consent except as otherwise required by law.

Today's Date ___/___/___

General Information

Name: ____ DOB: ____/____/____ Age: ______
Street Address:_______________________________________ Phone (W): ____-______-________
City: ___________________________State_____Zip________ Phone (H): ____-______-________
Email address:*_______________________________________Phone (C): ____-______-________
(*email correspondence is not considered a confidential medium of communication)
Calls or e-mail will be discreet, but indicate restrictions, if any: _______________________________
Emergency Contact: ____
Relationship: ___________________________ Phone #'s: ____________________________
May I ask who referred you? ____
May I contact him/her to thank them for the referral? _______ Yes _______ No

Your Medical Care

From whom or where do you get your medical care?

Clinic/doctor's name: _________________________________ Phone _____________________________
Address: ____
Date of last Physical Exam: ____________________________
If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate treatment? ❑**Yes** ❑**No**

Current Occupation

Current Employer: __________________________ Occupation______________________________
Title: _____________________________ Number of years in position: _________________
Previous Employment (include job title, dates): ____
____
____
____

Education and Training

Highest level of education: ❑ Grade 12 or below ❑ HS Graduate or Equivalent
❑ 1- 4 yrs of college ❑ Bachelors Degree ❑ Graduate Degree ❑ Trade School
Your adjustment to school ____

Religious and Racial/Ethnic Identification

Do you consider yourself to be spiritual or religious? ❑**Yes** ❑**No**
If yes, please describe ____
Ethnicity/national origin (or other similar way you identify yourself and consider important):

____

Please describe the main difficulty that has brought you to see me: ______________________
____
____
____

Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ❑ No ❑Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑Yes
If yes, please indicate:

When?	From whom?	Which medications?	For what?	With what results?

General Health and Mental Health

1. How would you rate your current physical health?
❑ poor ❑ unsatisfactory ❑ satisfactory ❑ good ❑ very good
Please list any specific health problems you are currently experiencing:
____
2. How would you rate your sleeping habits?
❑ poor ❑ unsatisfactory ❑ satisfactory ❑ good ❑ very good
Please list any specific sleep problems you are currently experiencing:
____
3. Please list any difficulties you experience with your appetite or eating patterns.
____
4. How much coffee, tea, sodas or other drinks with caffeine do you drink each day? ___________
5. Do you smoke or chew tobacco? ❑ No ❑Yes If yes, how much per week? ________________
6. Are you currently experiencing overwhelming sadness, grief or depression?
❑ No ❑Yes If yes, for approximately how long? _________________________________
7. Are you currently experiencing anxiety, panic attacks or have any phobias?
❑ No ❑Yes If yes, for approximately how long? _________________________________
8. Do you drink alcohol more than once a week? ❑ No ❑Yes
If yes, how much do you consume each week on the average? ______________________________

9. How often do you engage in recreational drug use?

❑ Daily ❑ Weekly ❑ Monthly ❑ Infrequently ❑ Never

10. What significant life changes or stressful events have you experienced recently:

____

____

Family of Origin

Relative	*Name*	*Current age (or age at death)*	*Illnesses (or cause of death, if deceased)*	*Education*	*Occupation*
Father					
Mother					
Stepparents					
Siblings					

Relationships in your family of origin: In a few words, how would you describe the following:

1. Your parents' relationship with each other: ____
____
2. Your relationship with each parent and with any other adults present: __________________
____
3. Your parents' physical health problems, drug or alcohol use, and mental or emotional difficulties:
____
____
4. Your relationship with your brothers and sisters, in the past and present: _______________
____

Family Mental Health History

Identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	Yes No	
Anxiety	Yes No	
Depression	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obsessive Compulsive Behavior	Yes No	
Schizophrenia	Yes No	
Suicide Attempts	Yes No	

Marital history

	Name of spouse	*Spouse's age at marriage*	*Your age at marriage*	*Your age when divorced/widowed*
First				
Second				
Third				

Present relationships

1. Are you currently involved in any romantic relationship (which may be noted above)? ❑ No ❑Yes
   If yes, how do you get along?

   ____
   ____
   ____

Children *(Indicate those from a previous marriage or relationship with "P" in the last column. Indicate stepchildren with "S.")*

Name	*Current age*	*Sex*	*P or S?*

2. If you have children, how would you describe your relationship(s) with them? ____________

____

____

3. Your important friends, past and present:

First names	Good parts of relationship	Bad parts of relationship

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

____
____
____
____