CLIENT QUESTIONNAIRE

Please provide the following information for your therapist to review.
Your information will be treated as private and confidential.

NAME: _____ TODAY'S DATE: _____/_____/_____

DATE OF BIRTH: _____/_____/_____ GENDER: ☐ Male ☐ Female ETHNIC BACKGROUND:

☐ Asian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other _____

YOUR COUNSELING NEEDS
What are the counseling issues that you would like to address?

_____

_____

_____

_____

_____

_____

Briefly describe the history of the problem(s):

_____

_____

_____

_____

SYMPTOMS
Check any of the following symptoms that you have been experiencing lately:

☐ Depressed Mood	☐ Little interest in pleasure activities	☐ Irritability	☐ Low self-esteem	☐ Fatigue
☐ Feeling of worthlessness	☐ Feeling of hopelessness	☐ Feeling of helplessness	☐ Excessive or inappropriate guilt	☐ Social withdrawal
☐ Anxiety	☐ Fear	☐ Panic	☐ Crying spells	☐ Indecisiveness
☐ Decreased ability to concentrate	☐ Decreased ability to complete tasks	☐ Marked functional impairment	☐ Hallucinations	
☐ Persistent elevated mood	☐ Inflated self-esteem	☐ Decreased need for sleep	☐ Pressured or increased speech	☐ Racing thoughts
☐ Restlessness	☐ Buying sprees	☐ Increased risky behavior	☐ Sexual indiscretions	☐ Impulsive business investments
☐ Shortness of breath	☐ Dizziness / faintness	☐ Rapid heartbeat	☐ Trembling / shaking	☐ Unexplained sweating
☐ Choking sensation	☐ Nausea or abdominal distress	☐ Numbness or tingling sensation	☐ Hot flashes / chills	☐ Chest pains or discomfort
☐ Fear of dying	☐ Fear of going crazy			

Sleep: ☐ Normal ☐ Insomnia ☐ Sleeping Too Much ☐ Wakefulness ☐ Nightmares

Average # of hours per night: _____

Appetite: ☐ Normal ☐ Loss ☐ Increased How Much? _____

Weight: ☐ Normal ☐ Loss ☐ Increased How Much? _____

STRESSES IN YOUR LIFE

What are some stressful events in your life in the last year or two (i.e., death of a loved one, job or family difficulties, disappointments, etc):

_____

_____

_____

CHILDHOOD HISTORY

How would you describe your childhood? ☐Happy ☐ Unhappy ☐Mixed Why?

_____

_____

What medical, behavioral or psychological problems did you have (or did others think you have) as a child? ☐None

_____

DIFFICULT LIFE EVENTS

Physical/Sexual Abuse in the Family ☐ No ☐ Yes _____

Substance Abuse in the Family ☐ No ☐ Yes _____

Other Traumatic events (divorce, death, etc.) ☐ No ☐ Yes _____

SUICIDE OR HOMICIDE

Have you had any recent thoughts of harming yourself? ☐ No ☐ Yes

Have you ever attempted suicide in the past? ☐ No ☐ Yes

If "yes", please describe when and how:

_____

Have you had any recent thoughts of harming someone else? ☐ No ☐ Yes

Have you attempted to kill someone in the past? ☐ No ☐ Yes

If "yes", please describe when and how:

_____

Do your have access to any weapons? ☐ No ☐ Yes _____

<u>RELATIONSHIPS AND SUPPORT SYSTEM</u>

☐ Single ☐ Married ☐ Married before (_____x's) ☐ Separated ☐ Divorced ☐ Widowed

Name of spouse or significant other:_____ For how long?: _____

Your children (if applicable) and ages: _____

Who currently lives with you? _____

Friendships: ☐ A lot of casual friends ☐ A lot of close ☐ A few close ☐ No close friends

How many of your close friends are completely sober? _____

SUBSTANCE USE

Alcohol	Currently:	☐ No	☐ Yes	How Much: _____	Past:	☐ No	☐ Yes
Tobacco	Currently:	☐ No	☐ Yes	How Much: _____	Past:	☐ No	☐ Yes
Marijuana	Currently:	☐ No	☐ Yes	How Much: _____	Past:	☐ No	☐ Yes
Rx drugs	Currently:	☐ No	☐ Yes	How Much: _____	Past:	☐ No	☐ Yes
Crack	Currently:	☐ No	☐ Yes	How Much: _____	Past:	☐ No	☐ Yes
Amphetamines	Currently:	☐ No	☐ Yes	How Much: _____	Past:	☐ No	☐ Yes
Opiates	Currently:	☐ No	☐ Yes	How Much: _____	Past:	☐ No	☐ Yes
LSD / Hallucinogens	Currently:	☐ No	☐ Yes	How Much: _____	Past:	☐ No	☐ Yes
Inhalants	Currently:	☐ No	☐ Yes	How Much: _____	Past:	☐ No	☐ Yes
Other narcotics	Currently:	☐ No	☐ Yes	How Much: _____	Past:	☐ No	☐ Yes
IV Drug Use	Currently:	☐ No	☐ Yes	How Much: _____	Past:	☐ No	☐ Yes
Caffeine	Currently:	☐ No	☐ Yes	How Much: _____	Past:	☐ No	☐ Yes
Eating Concerns	Currently:	☐ No	☐ Yes	What kind: _____	Past:	☐ No	☐ Yes

USE OF SUBSTANCES BY FAMILY MEMBERS:

Father	☐ No	☐ Yes	What and how often: _____
Mother	☐ No	☐ Yes	What and how often: _____
Siblings	☐ No	☐ Yes	What and how often: _____
Present Spouse	☐ No	☐ Yes	What and how often: _____
Former Spouse	☐ No	☐ Yes	What and how often: _____

SEXUAL HISTORY

Are you sexually active? ☐ No ☐ Yes, Since: _____

If "Yes", sex has been mostly ☐ Casual or ☐ In the context of serious relationship

For me has sex been ☐ Mostly positive ☐ A source of guilt, conflict or problems

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Not Sure

LEGAL HISTORY

Have you ever been arrested? ☐ No ☐ Yes, for: _____ When?_____

Do you have any legal charges currently pending? ☐ No ☐ Yes _____

LEISURE AND RECREATION

_____

OCCUPATION

Your job title: _____ Employed by:_____ How Long? _____

Work Schedule: ☐ Mon ☐Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun Hours per week: _____

What do you LIKE about your work?	What do you DISLIKE about your work?

EDUCATION

High School diploma? ☐ No ☐ Yes College Degree? ☐ No ☐ Yes Major:_____

Are you presently taking any classes? ☐ No ☐ Yes Major:_____

MILITARY HISTORY ☐ No ☐ Yes _____

FINANCIAL STRESS ☐ None ☐ Some ☐ A great deal

SPIRITUAL

What is your spiritual orientation? _____

What was your spiritual upbringing? _____☐ None

Do you attend a church/temple/synagogue? ☐ No ☐Yes _____

PSYCHOLOGICAL

Please provide information about counseling and/or inpatient treatment you have received in the past.

Date(s)	Level of Care (circle one)	For What Problem
Mo. Yr. Mo. Yr. From / to /	☐Outpatient Counseling ☐Inpatient	
Mo. Yr. Mo. Yr. From / to /	☐Outpatient Counseling ☐Inpatient	

Are you currently in treatment with any other counselor and/or psychiatric providers? ☐ No ☐ Yes

If yes, counselor's name(s):_____ Type of Counselor _____

Needs that are being addressed:

_____

Current Psychiatrist: _____Phone _____☐ None

CURRENT MEDICATIONS (Please list below):

Medication	For	Dosage	Schedule	Start Date	End Date
				____/____/____	____/____/____
				____/____/____	____/____/____
				____/____/____	____/____/____
				____/____/____	____/____/____

PHYSICAL HEALTH

Current Medical Issues? ☐ No ☐ Yes _____

_____

Current Primary Care Doctor? ☐ No ☐ Yes (Name) _____ Phone: _____

Date of Last Physical: _____

Previous Medical Issues? ☐ No ☐ Yes _____

END OF QUESTIONAIRRE