CLIENT QUESTIONNAIRE

GENERAL INFORMATION

Name: ______________________________ Date: ____________________

Address: ____

Work Phone: ____________ Cell Phone: ____________ May I Leave Msgs or Texts? Y / N

E-mail: ____

Date of Birth: ____________ Age: _____ Marital Status: ____________________

Occupation: ____________________ Education Level: ____________________

Spouse Name: ____________________ Spouse Occupation: ____________________

Names and Ages of children: ____

____

Emergency Contact: ______________________ Phone: ____________________

Vehicle Information

Make: ____________ Model: ____________ Color: ________

Driver's License #: ____________________ License Plate: ____________________

Referral Source: ____

AREAS OF CONCERN

What issue(s)/concern(s) cause(s) you to seek treatment? Please describe. ______________

____

____

What do you hope to gain from sessions? ______________________________

____

Do you have any particular concerns/ fears with regard to treatment? ______________

____

What is your interpretation of therapy? ______________________________

____

PSYCHOLOGICAL HISTORY

Have you ever received mental health treatment before? ____________________

When and for how long? ____

What was the focus of treatment? ____

Previous Therapist(s): ____

____

Have you ever been subjected to one or more psychological tests? __________________________

Please list Test/Year: ____

Have you ever been hospitalized for mental or emotional problems? _________________________

Hospital Name and Location: ____

When and for how long? ____

Why were you hospitalized? ____

Are you currently taking any prescription medications? Yes / No If so, please list: ____________

____

____

Have you ever attempted suicide? ________________ If so, when? _________________________

Describe the circumstances that led to that attempt: _____________________________________

____

Are you currently having any suicidal thoughts? If so, please describe: _____________________

____

Please describe your childhood: ____

____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe: _________

____

____

Have you ever been a victim of a violent crime? Please describe: __________________________

____

MEDICAL HISTORY

Have you ever been diagnosed with a serious illness? Please describe: _____________________

____

Do you have any medical conditions that may affect your mental health treatment? Yes / No

Please describe your overall health today: ____

Are you experiencing medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe: ____

____

Have you ever been in a 12-step program, detox, or rehab facility? Please describe: ______________

____

Have/Do you use any of the following substances:

Current Use   Past Use

Alcohol ____

Cigarettes ____

Energy Drinks ____

Marijuana ____

Illegal Substances ____

Other ____

FAMILY OF ORIGIN HISTORY

Mother's name, age, living/deceased, client's age at the time of mother's death, description of relationship with mother. ____

____

Father's name, age, living/deceased, client's age at the time of father's death, description of relationship with father. ____

____

Names and ages of siblings: ____

____

OTHER INFORMATION

Please describe your spiritual identity/orientation: ________________________

____

Please describe your interests/hobbies: ______________________________________

____

Are you now or have you ever been involved in a lawsuit? ____________________

Please describe: ____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested: ____

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