Client Information Questionnaire

Name:____________________________________ Today's Date:_______________
Form completed by:____________________ Relation to client:________________
Referred by:____
Address____
____
Home Phone:_________Work Phone:_____________ Cell Phone:_____________
Email:____
Birth date _________ Age:___ Sex:____ Occupation:______________________
Place of employment: __________________________________How long?_______

Current Marital Status: (circle) Single Married Widowed Divorced
Separated Unmarried Couple
If married, date of marriage: ______If previously married, list date(s): __________
Spouse's Name __________________________ Age _____Birth date: __________
Spouse's Employer ________________________ How long?___________________

Emergency Contact Person:______________________Phone # _______________
List members of your immediate family:

Name	Age	Relationship	In Home	Not in Home

Briefly describe your reason for seeking counseling at this time:
____
____

Rate the severity of your problem(s):
1______2______3______4______5______6______7______8______9______10
not severe at all — very severe

Describe the changes that you believe you need to make and what you expect to receive from counseling at this time:____
____

COUNSELING HISTORY

Have you had prior counseling? ____ If so, dates:____ and, reason:
____
Was it helpful? ______ Why, or why not? __________________________________

Have you ever been treated for a mental health problem? ___Yes ___NO
If yes, describe what you were treated for and when: _________________
____
Is there any family member who has a history of emotional problems or received psychological help? ____

PHYSICAL HEALTH

Name of Family Physician:______________ Ph.#___________ last seen: ______

Name of Psychiatrist: __________________ Ph.#___________ last seen: ______
List health problems for which you currently receive treatment __________
____
____
List medications that you are taking:
____
Have there been any changes in your health during the past year? _______
Check: ____ sleeping habits _____eating habits _____chronic pain

DRUG/ALCOHOL HISTORY

Do you drink alcohol including beer, wine, distilled spirits?____Yes ____ No
How often? _________________
Have you used drugs for other than medical purposes? ____Yes ____ No
If yes, what drugs?
____
How often? _________________
Have you ever been treated for a substance abuse problem? ____Yes ____ No
If yes, when: ____________________________________
Please list any family members who have a history of alcohol/drug use:
____

Have any of these people ever received treatment for their alcohol/drug use? _________
Has your drinking/drugs ever caused you problems (e.g., with family, work, school, legal problems, accidents, injuries)? ______ If yes, explain: ______________________
____

EDUCATIONAL/VOCATIONAL HISTORY

Education: Years of High School ___ College ___ Graduate work ______
Program of Studies:_____________
Does your work satisfy you? ____ If no, explain: ______________________
____
Has your current situation affected your job? ___________________________
Describe physical/emotional problems that prevent your being employed:
____

SPIRITUALITY

Religious Affiliation ____
Church? ________________________________ Active ___ Inactive ___
Are spiritual issues important to you in therapy? If so, describe:
____
____

MILITARY HISTORY

Have you ever served in the military? ___Yes ____No If yes, Branch:___________
Age at enlistment:______ Type of discharge: _______________
Did you ever serve in combat? ___Yes ___No If yes, describe:
____

LEGAL HISTORY

Any legal charges pending? ___Yes ___No If yes, explain: _________________

Are you seeking help in order to comply with a court order, the request of your lawyer, or to assist in pursuing a disability/workman's compensation claim? ___Yes ____No
If yes, please give specifics: ____
____

PERSONAL DESCRIPTION

This section is to gather information that will enable us to help you with your problems. Do not feel obligated to respond.
How would you answer the question "Who are you?" _______________________
____
Who would you turn to for help? ____
Describe what you do to relax: ____
How often do you exercise? ___Not at all ___1 – 2 times weekly
___3 – 4 times weekly ___5 or more times weekly

Circle any **LOSSES** that you have experienced:

Death of: spouse child father mother sister brother
grandmother grandfather friend
Divorce Separation Broken engagement Miscarriage Abortion Infertility Bankruptcy
Homelessness Career/Job loss Other:_______________

Circle any **VICTIMIZATIONS** or **PAINFUL EXPERIENCES** in your life:

Child abuse: physical, emotional, sexual, incest
Spouse abuse: physical, emotional, sexual
Abandonment Rape Robbery Assault Suicide attempt Auto accident
industrial accident Illness Major surgery Physical disability Chronic pain
Other:_________________

Circle any **PROBLEMS** that concern you now:

Relationships	Alcohol	Drugs	Binge eating	Excessive diet or exercise
Work too much	Shopping	Anger	Loneliness	Suicidal thoughts
Procrastination	Depression	Grief	Mood swings	Codependency
Communication	Career	Sex	Self-esteem	Health Problems
Gender identity	Anxiety	Stress	Energy	Legal Matters
Sleep Problems	Relaxation	Hopelessness	Temper	Self-control
Loss of Appetite	Memory	Parenting	Finances	Nightmares
Concentration	God	My Feelings	Church	Other: ______________
Helplessness	My Thoughts	Fear	My values	Other: ______________

Please add any additional information that you feel may be useful to us:
____
____

Thank you for completing this questionnaire.