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CLIENT QUESTIONNAIRE

The purpose of this questionnaire is to get a more complete picture of your personal, family and marital background without having to use a great deal of valuable therapy time. Please answer the questions as accurately as you can and feel free to ask any questions you have regarding the questionnaire.

Today's Date:_____________________

NAME:______________________________ AGE:_____________________
ADDRESS:___________________________ Date of Birth_______________
____
____

PHONE NUMBERS:__________________HOME __________________WORK
Can I call you at home? __________ at work? ________

OCCUPATION:____
PLACE OF WORK:____

EDUCATIONAL LEVEL (Please circle highest grade completed):
6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

CHILDREN:_____________(yes)________________ (no)
(If yes) NAMES and AGES:____
____
____
____
Live with you: FULL TIME__________ PART TIME___________

WHO REFERRED YOU?____

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1. Are you on any medication: (Please check one) YES______ NO______
IF YES, Please list NAMES OF MEDICATION, DOSAGE AND FREQUENCY TAKEN:
____

2. What is the general condition of your health?________________________________
When was your last medical checkup?_________
Physician's Name and Phone Number: ____

3. HAVE YOU EVER GIVEN SERIOUS CONSIDERATION TO, OR ATTEMPTED TO, END YOUR OWN LIFE?
YES_______NO_______IF YES, please describe:
____
____
____

4. In case of emergency please contact:
NAME:_______________________________PHONE:_____________________________

5. IS THERE A HISTORY IN YOUR FAMILY OF ANY OF THE FOLLOWING? Check all that apply:

sexual abuse_____ physical abuse_____
emotional abuse_____ rape_____
alcoholism/drugs_____ violence_____
sleep disorders _____ eating disorder____
physical conditions_____ if so, what kind?______________________
mental Illness_____ if so, what kind? ____

6. CHECK ALL OF THE FOLLOWING AREAS WHICH HAVE BEEN OR ARE A PROBLEM FOR YOU:

Marriage/partner YES___NO___ Family YES___NO___
Job/School YES___NO___ Health YES___NO___
Finances YES___NO___ Legal YES___NO___
Friendships YES___NO___ Mood YES___NO___
Anxiety Level YES___NO___ Eating habits YES___NO___
Spirituality YES___NO___ Anger YES___NO___
Alcohol YES___NO___ Drug(s) YES___NO___
Sexual difficulties YES___NO___ Caffeine YES___NO___
Smoking YES___NO___
Ability to control your temper YES___NO___

7. HAVE YOU RECEIVED COUNSELING BEFORE (Please check one): YES____ NO____
Type, length of time and approximate dates:_____________________________________
____
____
____
____

8. HOW DID YOU FEEL ABOUT THE OUTCOME?
____
____
____
____

9. BRIEFLY DESCRIBE YOUR REASONS for counseling now?
____
____
____
____

10. Is there anything I have not asked you that is important for me to know?
____
____
____
____
____
____
____
____