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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? _____

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?
