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CLIENT QUESTIONNAIRE

Name _____ Name you prefer to be called_____
Today's Date_____ Preferred pronouns_____

Home Phone_____ Is it OK to leave a message? ____yes _____no
Mobile Phone_____ Is it OK to leave a message? ____yes _____no

E-mail Address_____

Home Address_____

_____

Age_____ Birthday _____

Years of school completed_____

In school now?_____yes_____no

Occupation _____
Employed full time?_____yes_____no

Employer_____

Work Phone_____

WorkAddress_____

_____

Local person to notify in case of emergency_____
Relationship to you_____Home phone_____Work phone_____

Have you ever been in counseling/therapy before?____yes_____no
When?_____
Currently? _____

With whom?_____

Have you ever had a psychiatric hospitalization?_____ (if yes)
date(s)_____ Reason_____

Who referred you to me?_____May I acknowledge the referral?_____

(Continued on next page)

Are you:___single___dating regularly___married/partnered__divorced/separated___widowed

Who lived in your household when you were growing up?

Name	**Relationship**	**Occupation**	**Current age**	**Deceased?**

Who lives with you now?

Name	**Relationship**	**Occupation**	**Age**

Please check the box beside any issue that is troubling you now or has been troubling to you within the last six months:

❑Abuse (physical, sexual, emotional, or other) from others
❑ Abuse towards others, cruelty to animals
❑ Alcohol use
❑ Anger, hostility, arguing, irritability, aggression
❑ Anxiety, nervousness
❑ Attention, concentration, distractibility
❑ Career concerns, goals, and choices
❑ Childhood issues (your own childhood)
❑ Codependence
❑ Confusion
❑ Custody of children
❑ Decision making, indecision, mixed feelings, putting off decisions
❑ Delusions (false ideas)
❑ Dependence
❑ Depression, low mood, sadness, crying
❑ Divorce, separation, break-up

❑ Drug use (prescription medications, over-the-counter medications, street drugs)
❑ Eating problems (overeating, under-eating, appetite)
❑ Failure
❑ Fatigue, tiredness, low energy
❑ Fears, phobias
❑ Feeling of emptiness
❑ Financial or money troubles, debt, impulsive spending, low income
❑ Friendships
❑ Gambling
❑ Grieving, mourning, deaths, losses, divorce
❑ Guilt
❑ Headaches, other kinds of pains
❑ Health, illness, medical concerns, physical problems
❑Inferiority feelings
❑Infertility struggles
❑ Impulsiveness, loss of control, outbursts
❑ Irresponsibility
❑ Judgment
❑ Legal matters, charges, suits
❑ Loneliness
❑ Mood swings
❑ Motivation, laziness
❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Oversensitivity to rejection
❑ Pain, chronic
❑ Panic or anxiety attacks
❑ Parenting, child management
❑ Perfectionism
❑ Pessimism
❑ Procrastination
❑ Relationship/Marital conflict (distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
❑ Relationship problems with friends, with relatives, or at work
❑ School problems
❑ Self-centeredness
❑ Self-esteem
❑ Self-harm
❑ Self-neglect, poor self-care
❑ Sexual addiction concerns
❑ Sexual issues, dysfunctions, conflicts, desire differences
❑ Sexual identity concerns
❑ Shyness, oversensitivity to criticism
❑ Sleep problems (too much, too little, insomnia, nightmares)
❑ Smoking and tobacco use
❑ Spiritual, religious, moral, ethical issues
❑ Stress, relaxation, stress management, stress disorders, tension
❑ Suspiciousness, distrust
❑ Suicidal thoughts
❑ Temper problems, self-control, low frustration tolerance

- ❑ Thought disorganization and confusion
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholic/overworking, can't keep a job, dissatisfaction, ambition

Describe any illnesses, accidents, or hospitalizations that may have made a significant change in your life.

What prescription drugs to you use, and how often do you usually use them?

How much alcohol do you use, and how often do you usually use it?

What other drugs do you use, and how often do you usually use them?

How do you see your eating habits related to your physical and emotional health?

Is there anything else you think it is important for me to know?

Please read carefully the Psychotherapist-Client Agreement and the HIPAA Notice on my website (a copy of which is located in the black notebook kept in the waiting area of my office). Please let me know if you have questions or concerns. Before our first session I will ask you to sign a form indicating that you have read and understand this information. Thank you!