

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?
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Who lives with you now?

Name	Relationship	Occupation	Age
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 do 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!