CLIENT QUESTIONNAIRE

Full Legal Name: _____ DOB: _____/_____/_____

Preferred Name: _____ Email: _____

Address: _____
(Street) (City/State) (Zip Code)

Home Phone:_____ Cell Phone: _____

Can we leave voice messages for you at these numbers? Yes No Text Messages? Yes No

EMERGENCY CONTACT INFORMATION:

Name: _____ Home Phone: _____

Relationship: _____ Cell Phone: _____

Name: _____ Home Phone: _____

Relationship: _____ Cell Phone: _____

Hospital Preference: _____

CULTURAL IDENTIFICATION:

Sexual Identification: __Heterosexual (Straight) __Gay/Lesbian __Bisexual

__Other, Please Explain:_____

Gender Identity and Expression: _____

Ethnic Identification: __African American __Caucasian __Latino __Hispanic __Asian

__Native American __Other, Please Explain:_____

Religious/Spiritual Identification: __Catholic __Protestant __Non-Denominational Christian

__Jewish __Hindu __Muslim __Buddhist __Agnostic __Athiest __Jehovah's Witness

__Other: Please Explain:_____

Are you satisfied with your spirituality? Yes No

Please Explain:_____

_____

Client Name: _____

Marital Status: __Single __Partnered/Cohabitating __Married __Divorced __Separated

__Widowed __Other, Please Explain: _____

Employment Status: __Employed FT __Employed PT __Student FT __Student PT __Self-Empl.

__Unemployed __Other, Please Explain: _____

Please tell us a little bit about what is bringing you in today:

_____

_____

_____

_____

PSYCHOLOGICAL SYMPTOMS AND HISTORY:

Please check any of the following that are currently of concern to you:

__Feeling tense

__Past or present trauma

__Feeling lonely

__Low motivation/energy level

__Hopelessness

__Suicidal thoughts

__Mood swings

__Racing thoughts

__Worrying about what others think of me

__Negative thoughts about myself

__Eating disorder

__Sleeping too much

__Problems falling or staying asleep

__Grief and loss

__Difficulty controlling anger

__Substance use

__Gambling

__Seeing or hearing things that other people don't

__Couple's/relationship problems

__Worrying too much/feeling afraid

__Avoiding things I am afraid of

__Isolating/withdrawing

__Feeling numb

__Crying easily

__Self-injury

__Difficulty making decisions

__Feeling high (without substance use)

__Seeking reassurance from others

__My weight/appearance

__Chronic pain

__Not sleeping enough

__Nightmares

__Irritability

__Being violent or wanting to be violent

__Sex addiction

__Impulsivity

__Difficulty controlling thoughts

__Problems with my kids

Client Name: _____

HAVE YOU EVER EXPERIENCED THE FOLLOWING:

__Physical Abuse __Emotional/Verbal Abuse

__Sexual Abuse __Neglect

Have you ever abused another person? Yes No

Have you ever experienced a life-threatening event (i.e. combat, natural disaster, accident, serious injury, watched another person die, violent crime, etc.)? Yes No

Please explain: _____

_____

Have you ever experienced suicidal or self-injurious thoughts or behaviors in the past? Yes No

If so, please describe: _____

_____

PAST TREATMENT EXPERIENCES:

Have you ever participated in mental health therapy in the past? Yes No

If so, please describe: _____

_____

Have you ever been psychiatrically hospitalized in the past? Yes No

If so, please describe: _____

_____

Have you ever participated in partial hospital/IOP for mental health or substance abuse? Yes No

If so, please describe: _____

_____

Has anyone in your immediate family ever struggled with mental health conditions (i.e. anxiety, depression, suicide, substance use, etc.): Yes No

If so, please describe: _____

_____

Client Name: _____

HEALTH INFORMATION:

Who is your primary care physician? _____

Date of your last primary care visit: _____/_____/_____

Would you like to sign a release of information to involve them in your care with us? Yes No

If you are experiencing any current medical conditions that you believe could impact your mental health treatment, please describe them here:

_____

_____

_____

_____

_____

Please list all of the medications (prescribed or over-the-counter) that you are currently taking:

Medication:	Dosage:	Prescribed By:

Please list any psychiatric medications that you have been prescribed in the past:

_____

_____

Who is your current psychiatrist? _____

Date of your last psychiatry visit: _____/_____/_____

Would you like to sign a release of information to involve them in your care with us? Yes No

If you do not currently have a psychiatrist, are you interested in a referral for one? Yes No

Client Name: _____

FAMILY INFORMATION:

Please tell us about the other people living in your home:

Name:	Relationship to You:	Age:	Comments:

Do you have additional children who are not currently living in your home? Yes No

If so, please list them here:

Name:	Age:	Living With:	Comments:

Please list additional family members below (i.e. parents, siblings, step-family, adoptive family, ex-partners of importance, etc.):

Name:	Relationship to You:	Age (or age at death):	Comments (please comment if deceased):

Client Name: _____

LEGAL HISTORY:

What is your current legal status: __Clear __Awaiting Trial __Probation __Parole

__Other, Please Explain: _____

If you are currently experiencing legal problems, would you like to sign a release of information for your legal providers? Yes No

Please list any past legal charges and/or incarcerations:

Dates:	Charges:	Results (probation, incarceration. etc.):

EDUCATIONAL/OCCUPATIONAL HISTORY:

What is the highest level of education that you completed?

__Middle School __GED __High School Diploma __Some College, No Degree

__Associate's Degree __Bachelor's Degree __Master's Degree __Doctorate

Do you have any difficulties with learning? Yes No Difficulties with reading/writing? Yes No

Please list the past three jobs that you have had:

Place of Employment:	Position:	Length of Time Employed:	Comments:

Did you ever serve in the U.S. military? Yes No If so, what branch?_____

What years did you serve?_____ Did you experience combat? Yes No

Client Name: _____

SUBSTANCE USE SCREENING: (Only complete boxes 5-11 for currently used substances.)

1. Type of substance:	2. Current use?	3. Used in the past?	4. Age of first use?	5. How often and how much do you use (example: 4 beers 3 times/week or $20 worth 2 times/week)?	6. Withdrawal symptoms when you stop using?	7. Have you ever tried to stop or cut down?	8. Have you ever taken more than planned?	9. Has it caused problems (at work, financial, in relationships, health, legal, etc)?	10. Tolerance (have to use more to get the same effect)?	11. Have you continued to use despite it making your problems worse?
Alcohol	Y/N	Y/N			Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Cannabis/Marijuana	Y/N	Y/N			Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Opiates	Y/N	Y/N			Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Cocaine	Y/N	Y/N			Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Benzodiazepines	Y/N	Y/N			Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Methamphetamine	Y/N	Y/N			Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Hallucinogens	Y/N	Y/N			Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Inhalants	Y/N	Y/N			Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Caffeine	Y/N	Y/N			Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Nicotine	Y/N	Y/N			Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Other:_____	Y/N	Y/N			Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Other:_____	Y/N	Y/N			Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Other:_____	Y/N	Y/N			Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Please list any goals you would like to accomplish while in therapy:

Please list any strengths and resources that will help you to achieve your goals:

Feel free to write any other pertinent information you wish to share with us: