CLIENT QUESTIONNAIRE

Name:_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if minor under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date:_____/_____/_____ Age:_____ Gender:_____

Race/Country of Origin:_____

Highest Education Level Achieved:_____

Marital Status/ Please circle:
Never Married Married Separated Divorced Widowed Other

Please list any children/age:_____

_____

Address:_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May I leave a message? Y N

Cell Phone: ( ) May I leave a message? Y N

Email:_____ May I email you? Y N
**Please note: Email correspondence is not considered to be confidential*

Referred by (if any):_____

Please list your current physicians:_____

_____

Emergency Contact: _____
(Name/Relationship) (Phone)

Are you currently taking any prescription medications?

_____

Have you previously received any type of mental health treatment?

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good

Medical Issues:
_____

Please circle any specific symptoms you are currently experiencing:

Victim of abuse/neglect	Panic	Alcohol use
Grief/loss	Self harm	Illicit drug use
Loss of enjoyment	Mood swings	Excessive guilt
Irritability	Compulsivity	Relationship issues
Isolation	Weight gain/loss	Over-reactive
Fatigue	Poor body image	Difficulty trusting
Thoughts/attempts of suicide	Paranoia	Fear of rejection
Poor concentration	Hearing voices	Temper outbursts
Excessive worry	Disorientation	Hyperactivity
Legal concerns	Medical issues	Work issues

What significant life changes or stressful events have you experienced recently?

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship:

	Please Circle		List Family Member
Alcohol/Substance Abuse	yes	no	
Anxiety	yes	no	
Depression	yes	no	
Domestic Violence	yes	no	
Eating Disorders	yes	no	
Obsessive Compulsive Behavior	yes	no	
Schizophrenia	yes	no	
Suicide Attempts	yes	no	

ADDITIONAL INFORMATION:

What is your employment situation?_____

_____

What do you consider to be some of your strengths?_____

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

What would you like to accomplish in therapy?_____

_____

_____

Client Signature Date