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CLIENT QUESTIONNAIRE

Your Name: ____

Preferred Pronoun: ____

Address: ____

Phone: (Home) ______________________ (Work) _______________________________

(Cell)________________________ (Fax) _____________________

Please circle if voicemail or text messages can be left/sent: Yes / No

Email: ______________________________

Name(s) of caregiver(s) if client is a minor: ____

Emergency Contact: (Name) ____

(Phone) ________________ (Relationship) ___________________________

Referred by _______________________________________ Phone____________________

May I thank the referral source? Yes No (circle one)

Name and address of person financially responsible for bill:__________________________________

____

Medical Insurance: _____________________________ ID #: _________________________

REIMBURSEMENT

A monthly statement can be provided to you at the end of the month, to give to your insurance company for reimbursement. The amount of reimbursement will depend on your insurance company's policy for covering out-of network providers. Please indicate if you would like a monthly statement: **Y N**

BACKGROUND INFORMATION

Age: _____________ Gender: ____________ Date of birth: __________________ Ethnicity (circle one): Caucasian African American Hispanic Asian Other: _____________________________

Religious background: Protestant Catholic Jewish Muslim Buddhist No affiliation (circle one)

Other: _____________________________

Marital status: Single, never married Married Separated Divorced (circle one) Widowed Cohabiting

If you divorced, when did you divorce your previous partner? ____
How long were you married? ____ If you are widowed, when did your spouse die? ____

Education: (number of years completed) ___________ Area of study ____

Are you going to school now? No Yes (circle one) If yes, circle one: Full-time Part-time Are you working now? No Yes (circle one) If yes, circle one: Full-time Part-time Occupation: (place and position)

____

____

RELATIONSHIPS

Spouse / Partner

Name Age Occupation Where does he/she live?

____

How long have you been together? .

Children

Name Age Occupation Where does he/she live?

____

Name Age Occupation Where does he/she live?

____

Name Age Occupation Where does he/she live?

____

Name Age Occupation Where does he/she live?

____

People living in your home (children, partner, relatives, housemates):

Name Relationship

____ ____
____ ____
____ ____
____ ____
____ ____

Mother Name: ____

If deceased, year of death If living, Age Occupation Where does she live?

____

Father Name: ____

If deceased, year of death If living, Age Occupation Where does he live?

____

Siblings:

Name Age Occupation Where does s/he live?

____

____

____

HISTORY

Where did you grow up?____

Were your parents ever separated? Yes No (circle one) If yes, when?__________________________ Did your parents get divorced? Yes No (circle one) If yes, when? __________________________ Did they remarry? Yes No (circle one) If yes, when? __________________________

At what age did you move out of your parents' home? __________________________

What is the highest degree you earned in school? ______________ When? ______________

Did you ever leave a school you were enrolled in prior to completion? Yes No (circle one) If yes, give details: __________________________ Did you ever receive any special education services (e.g. academic tutoring, IEP, classroom accommodations, etc.)? Yes No (circle one) If yes, give details: __________________________

____

If you were physically disciplined as a child, were you ever injured as a result? Yes No (circle one) Did your parent or a person taking care of you ever purposefully injure you in other circumstances (that is, when you were not being disciplined)? Yes No (circle one)

Did you ever have sexual contact with someone else that you did not want? Yes No (circle one) Have you experienced or witnessed any traumas (events that felt life-threatening)? Yes No (circle one) Have you experienced physical or sexual abuse or assaults? Yes No (circle one)

Please provide some general information on your work history:

Type of job held How long?

____

____

____

MEDICAL

Do you currently have, or have you had in the past, any serious, chronic or recurrent health problems or disabilities?

Yes No (circle one)

If yes, please describe: ____

List dates of any hospitalizations you have had for physical problems:

Date Problem

____

____

____

When was your last physical examination by a doctor? ______________________________

What was the outcome? ____

Do any biological relatives have any history of psychiatric or emotional problems? Yes No If yes, which family members and what types of problems?

____

____

DRUG AND ALCOHOL USE

Do you use alcohol? Yes No (circle one)

How much per week? ____

Age drinking started: ______________________

Do you use other drugs? Yes No (circle one)

What kind:____

How much:____

Do you feel you have a problem with alcohol? Yes No (circle one)

Do you feel you have a problem with other drugs? Yes No (circle one)

Any previous drug/alcohol treatment (inpatient/outpatient)?

If yes, dates and locations:______________________________________

Has your drinking/drug use caused problems with family or relationships? Yes No (circle one)

Has your drinking/drug use caused problems with your job? Yes No (circle one)

Is it difficult for you to stop or control the amount you take? Yes No (circle one)

Have you been arrested for driving under the influence or other alcohol/drug related offense? Yes No (circle one)

LEGAL

Have you ever been involved in a lawsuit?

Yes No (circle one)

If yes, please describe the circumstances and give dates.

____

Have you ever been arrested for a crime?

Yes No (circle one)

If yes, please describe the circumstances and give dates.

____

____

WHAT IS BRINGING YOU IN TODAY?

Please describe, briefly, the problem(s) that bring you in to see me.

What are the symptoms, how intense are they, and how often do they occur?

____

____

____

____

Have there ever been problems like this before? Yes No (circle one)

If yes, when? ____

Are you presently seeing another therapist? Yes No (circle one)

If yes, please give us the following information:

Therapist's name: ______________________________ Date treatment began: ________________________

Therapist's address:____

Therapist's phone number: ____

Have you previously been in psychotherapy or counseling, including individual, group, marital or family therapy? Yes No (circle one)

If yes, please give us the following information:

Therapist's name(s), phone number(s) and address(es): ____

____

____

Date(s) of treatment : ____

Problem for which treatment was sought:____

If you have been in psychotherapy before, was it helpful? Yes No (circle one)

If yes, in what way was it helpful? ____ If not, in what way was it unsatisfactory? ____ Has

hospitalization or partial hospitalization for mental or emotional difficulties ever been recommended for you? Yes No (circle one) If yes, when and why? ____ Have you ever been hospitalized or participated in a partial hospitalization program for mental or emotional difficulties? Yes No (circle one) If yes, when and why? ____ Was the hospitalization voluntary? Yes No (circle one)

Has a physician/psychiatrist ever recommended that you take medication for mental or emotional difficulties (e.g. Prozac, Xanax, etc.)? Yes No (circle one)

If yes, what medications were recommended, when and for what symptoms?

____

Have you ever taken medications for mental or emotional difficulties prescribed by a physician/psychiatrist? Yes No (circle one)

If yes, what medications were prescribed, when and for what symptoms?

____

Are you currently using any prescribed medications? Yes No (circle one)

Please indicate what medications you are CURRENTLY taking:

Medication Dosage When started Prescriber

____

____

____

____

____

Have you experienced any particular sources of stress in the last year?

Yes No (circle one)

If yes, please explain: ____

____

Are there any other health care professionals (e.g. physicians, psychotherapists, etc.) whom you feel might have information that would help in your treatment?

Yes No (circle one)

If yes, please give details: ____

____

____

____ Is there any other background information you think would be helpful for me to know?

Yes No (circle one)

If yes, please explain: ____

____

____

____

____

Signature ____

Date____