Client Questionnaire

Client Name________________________________ **Today's Date**_________________________

Date of Birth _________________

Name of Person Completing Form (if not client) ___________________________

Marital Status of Client

☐ **Never Married** ☐ **Divorced**
☐ **Married** ☐ **Widowed**
☐ **Cohabitating** ☐ **Separated**

Sex of Client

☐ **Male**
☐ **Female**

Custody
(if client is a child)

☐ **Mother**
☐ **Father**
☐ **Joint**
☐ **Other**

Present Living Arrangement: ☐**Alone** ☐**Family** ☐ **Guardian** ☐ **Friends** ☐ **Other**

Immediate Family

Name of Family Member	Age	Sex	Relationship to Client	Lives in Home	Lives Out of Home

Notify in case of Emergency
Name_______________________________ Address________________________
Home #_____________________________ Work/Cell_______________________

Family Doctor or Psychiatrist ____
Address____
Phone#_____________________________ FAX _________________________

Initial if OK to call in case of Emergency___________ Date_______________

Current Occupation___________________________________ **Full-time** ☐ **Part time**☐

Military Service **Yes** ☐ **No**☐ **Describe**_____________________________________

Legal Problems **Yes** ☐ **No**☐ **Describe**______________________________________

Name: ______________________________________

Symptom and Problem Checklist

Please check any or all of these that apply to you. Leave the box blank if this does NOT apply to you.

	Last 2 wks	Last 6 months	Past (over a yr)
Depressed or Sad Mood	☐	☐	☐
Lack of Interest/Pleasure in daily activities	☐	☐	☐
Appetite Changes	☐	☐	☐
Sleep Problems	☐	☐	☐
Restlessness	☐	☐	☐
Trouble Concentrating or Distractibility	☐	☐	☐
Difficulty Making Decisions	☐	☐	☐
Fatigue/Low Energy	☐	☐	☐
Feelings of Worthlessness/Guilt	☐	☐	☐
Feelings of Hopelessness	☐	☐	☐
Recurrent Thoughts of Death	☐	☐	☐
Racing Thoughts	☐	☐	☐
Rapid/Extreme Mood Swings	☐	☐	☐
Psychological/Verbal Abuse	☐	☐	☐
Physical Abuse	☐	☐	☐
Sexual Abuse	☐	☐	☐
Difficult or Traumatic Events	☐	☐	☐
Intrusive or Painful Memories	☐	☐	☐
Recurrent Distressing Dreams, Nightmares	☐	☐	☐
Sense of Reliving Difficult Events	☐	☐	☐
Periods of Time You Can’t Remember	☐	☐	☐
Intense Emotional Reactions	☐	☐	☐
Avoidance of Thoughts/Feelings	☐	☐	☐

Name: ___________________________________

	Last 2 wks	Last 6 months	Past (over a yr)
Feeling Detached, Unreal OR Numb Inside	☐	☐	☐
Unreasonable Thoughts/Beliefs	☐	☐	☐
Hallucinations	☐	☐	☐
Agitation/Aggression	☐	☐	☐
Trouble Controlling Anger	☐	☐	☐
Chronic Anger Inside/Resentment	☐	☐	☐
Impulsive Behavior	☐	☐	☐
Stealing	☐	☐	☐
Lying	☐	☐	☐
Uncooperative with Others	☐	☐	☐
Defiant Behaviors	☐	☐	☐
Dizzy/Short of Breath	☐	☐	☐
Accelerated Heart Rate/Chest Pains	☐	☐	☐
Trembling/Shaking	☐	☐	☐
Sweating/Feelings Flushed	☐	☐	☐
Choking Sensations	☐	☐	☐
Nausea/Abdominal Distress	☐	☐	☐
Numbness/Tingling Sensations	☐	☐	☐
Recurring or Intrusive Thoughts	☐	☐	☐
Fear of Dying or Going Crazy	☐	☐	☐
Fear of Persons/Places/Animals/Situations	☐	☐	☐
Recurring and Persistent Thoughts/Behaviors	☐	☐	☐
Forgetfulness/Memory Problems	☐	☐	☐
Feeling Overwhelmed	☐	☐	☐
Anxiety/Increased Stress	☐	☐	☐
Paranoia	☐	☐	☐
Low Self-Esteem, Feeling Inferior	☐	☐	☐

Name: ___________________________________

	Last 2 wks	Last 6 months	Past (over a yr)
Changes in Self-Care **(eating, dressing, working)**	☐	☐	☐
Physical Symptoms/Pain/Health Problems	☐	☐	☐
Relationship Problems	☐	☐	☐
Problems at Work, School, or Home	☐	☐	☐
Withdrawing from Relationships	☐	☐	☐
Social Isolation/Lack of Friends	☐	☐	☐
Communication Problems	☐	☐	☐
Poor Grades	☐	☐	☐
Cruelty to Animals	☐	☐	☐
Fire setting	☐	☐	☐
Gambling	☐	☐	☐
Overuse of Alcohol or Drugs	☐	☐	☐
Bingeing on Alcohol or Drugs	☐	☐	☐
Bingeing/Compulsive Overeating	☐	☐	☐
Intentional Vomiting	☐	☐	☐
Laxative/Diuretic Misuse	☐	☐	☐
Excessive Dieting	☐	☐	☐
Compulsive Exercising	☐	☐	☐
Suicidal Ideation	☐	☐	☐
Suicidal Ideation with a Plan	☐	☐	☐
Suicide Attempts	☐	☐	☐
Homicidal Ideation	☐	☐	☐
Homicidal Ideation with a Plan	☐	☐	☐
Assaultive Ideation	☐	☐	☐
Actual Assaults	☐	☐	☐
Self-Injury/Self-Mutilation/Cutting	☐	☐	☐

Name: ________________________________

Medical and Psychological History

Please describe/list any medical and/or psychological conditions you have experienced. Do the same in the boxes that are not “XXXed’ out for close family members.

Condition/Issue/Event	Myself	Close Family Member
Significant Surgeries		XXXXXXX
Accidents/Head Injury		XXXXXXX
Hospitalizations		XXXXXX
Thyroid Problems		XXXXXX
Sleep Apnea/Insomnia		XXXXXX
Depression		
Anxiety/Panic Disorder		
Obsessive/Compulsive Behavior		
Alcohol/Substance Abuse		
Gambling, Overspending		
Previous Therapy		XXXXXX
Current Medications		XXXXXX

Please List Some of Your Strengths/Assets as a Person:____

____

Please List Some of Your Struggles/Challengesas a Person:__________________________________

____

What Help Would You Like to Have Through this Therapy? ___________________________________

____

____

Name: ______________________________________

Family with Whom You Grew Up:

Name of family Member	Age (or years older or younger than you)	Relationship to you

Social History:

List important, especially difficult or life-changing events you have experienced that have had an impact on you. These may include illnesses, losses, surgeries, birth trauma, concussions, medical conditions, earliest memory, etc. Please describe the impact these events have had on your lifestyle.

Name: ___________________________________

Please describe any additional Information you would like me to know about you that has not been inquired about in this questionairre: