New Client Questionnaire

Personal Information:

Name: ____Gender: _________Date:_________________________

Age:___________ Ethnicity: ______________________ Sexual Orientation:______________________________

Date of Birth: __________________Place: ____

Phone(Cell/Work) ____________________________ (Home)____

May I contact you and leave messages at one or both of these phone numbers? _____Yes _____No

Address:____City:_________________________________

State: ________ Zip:___________ Email: ____

May I mail you at this address: _______Yes _______No; May I email you? _____Yes _____No

Emergency Contact ___________________________________ Phone: _________________________________

Emergency Contact's Relationship to You: _______________________________

Medical Doctor(s) (name/phone):____

Occupation: ______________________________________ Employer:__________________________________

How long have you worked there?: _________________ How long in this occupation?___________________

Referral Source:____

May I inform this person that you have consulted with me? ____

Education:

What is the highest level of education you have attained? ____

Are you currently in school? ________ Yes ________ No

If you are in college, what are you studying? ____

If you have not yet completed high school, what grade are you in now? _________________________________

Reason for Seeking Therapy (be as specific as you can: when did it start, how does it affect you in...):

____

____

____

____

____

____

____

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Have you been in therapy before? If so, when and on what issues did you focus? Whom did you see?

____

____

____

What are your main worries and fears?

____

____

What do you identify as your strengths?

____

____

What do you identify as your weaknesses?

____

____

Please check if there has been any recent changes in the following:

- ___ Sleep patterns
- ___ Physical activity level
- ___ Eating patterns
- ___ General disposition
- ___ Behavior
- ___ Weight
- ___ Focus
- ___ Energy level
- ___ Nervousness/Tension
- ___ Other (specify)_________________

Describe changes in areas in which you checked above:

____

What would you like to focus on in therapy?

____

____

____

Assuming that you achieved your goals for coming to therapy, what would some of your gains look like?

____

____

____

Relationship Information:

Current Marital Status:________________ Do you live with someone:______

Name:____ #Years:_____

Past & Present Marriage(s) (years together, names and statement about the nature of the relationship(s) i.e., friendly, distant, physically/emotionally abusive, loving, etc.) ____

____

____

____

____

Present Spouse/Partner: Education:__________________________ Occupation:___________________________

Children/Step/Grand: (name/ages and brief statement on your relationship with the person)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Parent/Step Parent: (name/age or year of death/cause of death, occupation, personality, how did they treat you, brief statement about the relationship):

Father: ____

____

Mother:____

____

Step Parents: ____

____

If Parents Divorced: Your age at the time:____

Describe how it affected you at the time:____

____

Siblings: (name/age, if dead: age and cause of death and brief statement about the relationship):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Describe your childhood in general (relationships parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

____

____

____

____

Family Medical and Psychiatric History:

Describe any physical or mental illnesses that run in the family including depression or suicide:

____

____

Describe any abuse of substances that runs in the family:

____

____

Describe any history of violence or emotional/physical abuse:

____

____

Past/Present Psychotherapy: Please specify the month year(s) (beginning-end), estimated number of sessions, name and degree of therapist, initial reason for therapy, individual/couple/family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. ____
   ____
2. ____
   ____
3. ____
   ____

Have you ever experienced the following:

	Yes	No	When	Where	Your reaction to overall to experience
Therapy/Counseling	___	___	___________	_____________	___________________________
Suicidal Thoughts/Attempts	___	___	___________	_____________	___________________________
Drug/Alcohol Treatment	___	___	___________	_____________	___________________________
Hospitalizations	___	___	___________	_____________	___________________________

If you have experienced suicidal thoughts/suicide attempt(s) or any other violent behavior, please describe (described: ages, reasons, circumstances, how etc.):

____

____

Please check behaviors and symptoms occur to you more often than you would like them to take place:

— Aggression	— Elevated mood	— Phobias/fears
— Alcohol dependence	— Fatigue	— Recurring thoughts
— Anger	— Gambling	— Sexual addiction
— Antisocial behavior	— Hallucinations	— Sexual difficulties
— Anxiety	— Heart palpitations	— Sick often
— Avoiding people	— High blood pressure	— Sleeping problems
— Chest pain	— Hopelessness	— Speech problems
— Cyber addiction	— Impulsivity	— Suicidal thoughts
— Depression	— Irritability	— Disorganized thoughts
— Disorientation	— Judgment errors	— Trembling
— Distractibility	— Loneliness	— Withdrawing
— Dizziness	— Memory impairment	— Worrying
— Drug dependence	— Mood shifts	— Other
— Eating disorder	— Panic attacks	

Briefly discuss how the above symptoms impair your ability to function effectively:________________________

____

____

____

____

____

____

Medical/Physical Information:

Past/Present Medical Care (major medical problems, surgeries, accidents, falls, illness-please include dates):

____

____

____

Are you taking any medication(s) at this time? ____

Prescription Drugs:

Type	Amount	Frequency	Date Last Used

Past/Present Drug/Alcohol Use/Abuse (AA, NA, treatments):

____

____

Coffee (#______ cups/daily)

Cigarettes (#______ per day)

Alcohol (#______ drinks/daily______ or weekly______) Date last drank:__________________

Street Drugs:

(Type):______________________ Frequency:_________ Age of First Use_____Date of Last Use__________

(Type):______________________ Frequency:_________ Age of First Use_____Date of Last Use__________

(Type):______________________ Frequency:_________ Age of First Use_____Date of Last Use__________

(Type):______________________ Frequency:_________ Age of First Use_____Date of Last Use__________

Substance of preference:____

Describe when you typically use substances:____

Describe any changes in your use patterns:____

Reasons for use:

— Addicted
— Build confidence
— Escape
— Self-Medication
— Socialization
— Taste
— Other

Does/has someone in your family present/past have/had a problem with drugs or alcohol? ___Yes ___No

If yes, describe:____

Have you had adverse reactions or overdosed drugs or alcohol?

(Describe):____

Any past or current legal issues with substances? (DUI, DWI etc.) ___Yes ___No

If yes, describe:____

List any current health concerns:____

List any recent health or physical changes:____

Sexual Concerns (describe any concern/problems/questions you have related to sex, for example: pain, performance issues, lack of desire/pleasure, compulsiveness/addiction, sexual trauma, relationship issues, etc.):

____

____

____

Please check any medical/physical health issues that apply to you:

— AIDS
— Alcoholism
— Abdominal pain
— Abortion
— Allergies
— Anemia
— Appendicitis
— Arthritis
— Asthma
— Bronchitis
— Bedwetting
— Cancer
— Chest pain
— Cold/cough's
— Constipation
— Chickenpox
— Dental problems
— Diabetes
— Diarrhea
— Dizziness
— Drug abuse
— Epilepsy
— Ear infections
— Eating problems
— Fainting
— Fatigue
— Frequent urination
— Headaches
— Hearing problems
— Hepatitis
— High blood pressure
— Kidney problems
— Measles
— Mononucleosis
— Mumps
— Menstrual pain
— Miscarriages
— Neurological disorders
— Nausea
— Nosebleeds
— Pneumonia
— Rheumatic fever
— Sexually-transmitted diseases
— Sleeping disorders
— Sore throat
— Scarlet fever
— Sinusitis
— Smallpox
— Stroke
— Sexual problems
— Tonsillitis
— Tuberculosis
— Toothache
— Thyroid problems
— Vision problems
— Vomiting
— Whooping cough
— Other

Nutrition:

Meal	How Often	Typical Foods Eaten	Typical Amount Eaten
Breakfast	___/week	____________________	__low __med __high __none
Lunch	___/week	____________________	__low __med __high __none
Dinner	___/week	____________________	__low __med __high __none
Snacks	___/week	____________________	__low __med __high __none

Comments:____

Do you engage in eating disordered behavior? ___Yes ___No

If yes, describe: ___Restricting ___Binging ___Purging ___Extreme Diets ___Other:____________________

Development:

Are there any special, unusual, or traumatic circumstances affected your development? ___Yes ___No

If yes, please describe:____

Has there been history of child abuse? ___Yes ___No

If yes, which type(s)?___Sexual ___Physical ___Verbal

If yes, the abuse was as a: ___Victim ___Perpetrator

Other childhood issues: ___Neglect ___Inadequate nutrition ___Other (please specify) _________________

Comments:____

How did you experience puberty (early developer, late developer etc.):______________________________

____

Social Relationships:

Check how you generally get along with other people: (check all that apply)

__Affectionate	__Aggressive	__Avoidant	__Fight/Argue Often
__Friendly	__Follower	__Leader	__Outgoing
__Shy/Withdrawn	__Submissive	__Other (specify)_______________	

Any concerns about social relationships? (Specify)

____

____

Culture/Ethnic:

To which cultural or ethnic group, if any, do you belong?_______________________________

Are you experiencing any problems due to cultural or ethnic issues? ___Yes ___No

If yes, describe: ____

Other Cultural/Ethnic Information:____

Religious/Spiritual:

How important to you are spiritual matters? ___Not ___Little ___Moderate ___Much

Are you affiliated with a spiritual or religious group? ___Yes ___No

If yes, describe:____

Were you raised within a spiritual or religious group? ___Yes ___No

If yes, describe:____

Would you like your spiritual/religious beliefs incorporated into the therapy? ___Yes ___No

If yes, describe:____

Are you seeking therapy for issues regarding religion/spirituality? ___Yes ___No

Military:

Military experience? ___Yes ___No Combat experience? ___Yes ___No

Where: ____

Branch: ____________________________ Discharge Date: ____________________________

Date Drafted:__________________________ Type of Discharge:___________________________

Date Enlisted: _________________________ Rank at Discharge:___________________________

Leisure/Recreational:

Describe special areas of interest or hobbies (e.g. art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling etc.)

Activity How often now? How often in the past?

____

____

____

____

____

Friendships, Community, and Spirituality (describe quality, frequency, activities, etc.):

____

____

____

What gives you most joy or pleasure in your life?

____

____

Referral Source:

How were you referred to me? ____

Financially Responsible Person's Information:

Name ______________________ Relationship to Client ______________________

Phone (if different from above) ______________________________________

Address (if different from above) ____________________________________

Do you qualify for Medicare?____ Yes ____No