Client History and Information Questionnaire

CONFIDENTIAL

The following information will be used to provide your counselor with information to assist them in forming a complete and accurate clinical understanding of you. Please complete this form to the best of your knowledge. If you are unable to answer a question you may leave it blank and discuss the information when you meet with your counselor. Please complete all pages and use additional pages as needed to answer any questions. Thank you for your assistance.

CLIENT IDENTIFYING INFORMATION

______________________ ______________ ____________
FULL NAME DATE OF BIRTH AGE

______________________ ______________ OK to Contact
STREET ADDRESS HOME PHONE

______________________ ______________ OK to Contact
CITY/STATE/ZIP MOBILE PHONE

______________________ OK to Contact
EMAIL ADDRESS

If the above individual is a Minor, complete the following:

______________________ ______________
PARENT/GUARDIAN NAME CONTACT NUMBER

INSURANCE INFORMATION: SELF SPOUSE CHILD

______________ ______________ ______________
INSURANCE COMPANY INSURED FULL NAME DATE OF BIRTH

______________ ______________ ______________
ID NUMBER GROUP NUMBER COPAY

EMERGENCY CONTACT:

______________ ______________ ______________
NAME RELATIONSHIP NUMBER

WHO REFERRED YOU TO US? ______________________________

DEMOGRAPHIC INFORMATION

WHAT IS YOUR RACE/ETHNICITY? ___________________________________

WHAT IS YOUR SEXUALITY?

HETEROSEXUAL GAY LESBIAN

CURRENTLY I AM:

SINGLE MARRIED PARTNERED COMMITTED RELATIONSHIP

DIVORCED WIDOW/WIDOWER

HIGHEST LEVEL OF EDUCATION: ____

EMPLOYMENT STATUS:

FULL TIME PART TIME UNEMPLOYED SELF-EMPLOYED

RETIRED STUDENT

SCHOOL NAME: ___________________________________

PRESENTING CONCERNS

Please state, in your own words, the nature of your current complaint or problem:

Please describe your goals and expectations for therapy. What do you want to accomplish in therapy?

What stressors may have contributed to the current complaint or problem?

Please indicate the areas of your life in which your problems are having an impact.

JOB/SCHOOL PERFORMANCE
SOCIAL RELATIONSHIPS
FAMILY RELATIONSHIPS
ROMANTIC RELATIONSHIPS
HEALTH
OTHER: ________________________

How long have you had these problems? ____________________________

Check all the words/phrases that describe what you are experiencing:

Substance abuse/dependence
Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.)
Depression/Sad/Down feelings
High/Low energy level
Angry/Irritable
Loss of interest in activities
Difficulty enjoying things
Crying spells
Decreased motivation
Withdrawing from people/Isolation
Mood Swings
Black and white thinking/All or nothing thinking
Negative thinking
Change in weight or appetite
Change in sleeping pattern
Suicidal thoughts or plans/Thoughts of hurting yourself
Self-harm/Cutting/Burning yourself
Homicidal thoughts or plans/Thoughts of hurting others
Poor concentration/Difficulty focusing
Feelings of hopelessness
Feelings of Worthlessness
Feelings of shame or guilt
Feelings of inadequacy/Low self-esteem
Anxious/Nervous/Tense feelings
Panic attacks
Racing or scrambled thoughts
Bad or unwanted thoughts
Flashbacks/Nightmares
Muscle tensions, aches, etc.
Hearing voices/Seeing things not there
Thoughts of running away
Paranoid thoughts
Feelings of frustration
Feelings of being cheated
Perfectionism
Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs
Distorted body image (believe you are heavier or less attractive than others say you are)
Concerns about dieting

Feelings of loss of control over eating
Binge eating/Purging
Rules about eating/Compensating for eating
Excessive exercise
Indecisiveness about career
Job problems

Social shyness
Chronic pain
People pleasing
Passive in relationships
Get too “hyper”
Major health diagnosis
Other: ________________________

PSYCHOLOGICAL/MEDICAL HISTORY

Have you had any previous psychological treatment?

Counseling: **YES** **NO**

When? ___________________________ By Whom? ____________________

For What Reason? ____

What did you like or dislike about your previous counseling experience?

What did you learn about yourself through previous treatment/counseling?

Hospitalization: **YES** **NO**

When? ___________________________

For What Reason? ____

Are you currently or actively thinking about hurting yourself or someone else? **YES** **NO**

Have you ever attempted suicide? **YES** **NO** If yes, please explain in more detail:

What medications do you currently take?

NAME	DOSAGE	REASON
______________________________	__________	______________________________
______________________________	__________	______________________________
______________________________	__________	______________________________
______________________________	__________	______________________________
______________________________	__________	______________________________

Other health concerns, serious illness, conditions, or major operations requiring hospitalization in your lifetime:

How would you rate your current physical health?

Excellent   Very Good   Good   Fair   Poor   Very Poor

Do you currently smoke cigarettes?   **YES**   **NO**   If yes, how much? ______________

Do you drink alcohol?   **YES**   **NO**

How often: ____________ days/week

Amount: ______________ drinks/use

Have you used illegal medications or drugs?   **YES**   **NO**

If yes, describe the drug(s) and dates you used drug(s)?

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE RESPONDED TO THIS QUESTIONNAIRE AS COMPLETELY AND CANDIDLY AS YOU ARE ABLE.

____   ______________________

SIGNATURE   DATE

____

PRINTED NAME