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NEW CLIENT QUESTIONNAIRE

Welcome! Thank you for taking a few minutes to fill out this form. The information you provide is confidential and will be helpful for you and your counselor when you meet for the first time. If you have any questions, just ask!

Today's Date_____

Name _____ Age _____

Date of Birth _____/_____/____

Address

_____

street city state zip

Phone (Primary) _____ (Secondary)_____

Email (please print clearly) _____

Education _____ Occupation _____

What is your religious background or involvement? _____

Emergency contact person (name, relationship, phone, address).

Name_____Phone_____

Relationship _____ Address_____

Living with you? _____ _____

Have you participated in any therapy before? Y___N___ If yes, when? _____ Reason _____ Are you, currently seeing a psychiatrist, therapist, or helper? Y____ N___
Have you or a family member ever been hospitalized for mental or emotional illness? Y_____ N_____
If yes, please explain—dates, where, reason:

_____

Substance abuse / addiction history? No _____ Yes (please explain)

_____

Legal History (arrests, prison, DWI, parking tickets?)

_____

Medical Information: Doctor's name and phone

_____

May we send your doctor a short note, letting him / her know you've come to see us? (we do not release details other than your name, for referral purposes) Y____ N____

Are you on any medications? Y___N___ If so, what and why?

How can we help? Please tell us in your own words what brings you here today

_____

_____

Common problem/symptom checklist. Fill in: 0 - none, 1 - mild, 2 - moderate, 3 - severe.

___marriage ___pre-marital ___being single ___sexual issues ___family ___children ___parents ___in-laws

Family Information:

___divorce/separation ___child custody ___disabled ___work/career ___school/learning ___money/ budgeting ___aging/dependency ___weight control

___alcohol/drugs ___other addictions ___grief/loss ___depression ___fear/anxiety ___anger control ___loneliness ___mood swings

___God/faith ___church/ministry ___past hurts ___codependency ___intimacy ___communication ___self-esteem ___stress control

Marital Status (check any that apply): Single ___ Dating ___ Committed relationship ___ Engaged ___ Married ___ (how long? _____) Separated ___ (how long? _____) Divorced ___ (how long?_____)

Spouse's Name (if applicable) _____ Age _____

Occupation _____

I would describe my friendships as: Close ___ Somewhat close____ Distant____ Conflicted____ I would describe my relationship with my mother as: Close ___ Somewhat close____ Distant____ Conflicted____ I would describe my relationship with my father as: Close ___ Somewhat close____ Distant____ Conflicted____

How many siblings do you have? _____ How would you describe your relationship? _____

Crisis Information: Are you having any current suicidal thoughts, feelings or actions? Y_____ N_____ If yes, explain _____

Any current homicidal or violent thoughts or feelings, or anger-control problems? Y_____ N_____

If yes, explain _____ Any issues, hospitalizations, or imprisonments for suicidal or assault behavior? Y_____ N_____

If yes, describe _____ Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Y____ N___

If yes, describe _____ Who referred you to us? _____

THANK YOU for taking the time to fill out this information sheet. This will be reviewed with you during your first counseling