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Date:_____

Confidential Client Questionnaire

Name:_____DOB:_____Age:_____
Name:_____DOB:_____Age_____
Social Security # _____ Place of Birth_____ _____

If Child is the client-Name_____DOB_____Age___SS#_____
Parent or Guardian, if client is a minor_____

Address:_____City_____
State_____ Zip Code: _____email_____
Home Phone:_____May I contact you at this number? Yes No
Work Phone: _____May I contact you at this number? Yes No
Cell Phone: _____May I contact you at this number? Yes No:
Education: _____
Relationship Status: _____ Years: _____
Religious Orientation (if any): _____Currently active?_____

Previous counseling? Yes No If yes, when, where, and what was the problem and the result._____
_____
_____
Please list any health problems or infectious diseases you have: _____
_____
Name of your Physician: _____

Family and significant other include their names:

Mother: _____ Father:_____

Are they still married to each other? ____If not, <u>your age at time</u> of divorce or death:___
Sisters: _____
Brothers: _____
Spouse/Partner: _____
Children: Names and ages_____

Please circle any of the following concerns that may pertain to you:

ADD/ADHD	Fears/Worries	Paranoia
Agitation	Feeling Worthless	Parent/Child Issues
Alcohol/Drug Use	Feelings of Isolation	Perfectionism
Anger/Temper	Guilt	Relationship Issues
Anxiety	Health Problems	Self-Confidence
Being Gay/Lesbian	Hopelessness	Self-Control
Career Choices	Inferiority Feelings	Self-Injury
Chronic Pain	Lack of Motivation	Sexual Problems
Communication issues	Legal Problems	Sleep Issues
Death of Loved One	Making Decisions	Stress
Depression	Marriage/Divorce	Suicidal Thoughts
Domestic Violence	Memory/Concentration	Temper
Eating Problems	Nervousness	Terminal Illness
Extreme Mood Changes	Obsession/Compulsion	Trust Issues/Jealousy
Fatigue	Panic Attacks	Weight Change
Fearing Failure	_	Work related issues

Has any family member ever had a drinking problem, a nervous breakdown, drug addiction, mental disorder, or attempted suicide?
Please describe:

_____
_____
_____

Briefly describe your specific reason (s) for seeking counseling at this time:

_____
_____

What is your average *daily* intake of caffeinated drinks? _____
What is your average *weekly* intake of alcoholic drinks? _____
Any recent increase? Yes ____ No _____

List any drugs you are using or have used, legal or illegal:

_____

Who referred you to me_____

May I thank this person?- yes____ no_____
Emergency Contact – Name, relationship and phone number:

_____

Signature_____Date_____