Client Questionnaire

This form will help us get started quickly in providing you with assistance. Please answer the following questions in order to help me get an understanding your present situation, concerns, and goals for therapy. We will be able to discuss any of these issues more fully when we meet. Feel free to skip any questions that don't apply to your situation. Please bring this with you on your first visit. Thank you.
Note: If you were a patient here before, please fill in only the information that has changed.

Date:_____

Name:_____Date of Birth: _____

Address:_____

Email:_____PH:_____

1. What are issues or problems that are causing you to seek help at this time?

2. What goals would you like to achieve as a result of our work together?

3. What are the emotional, physical, or psychological symptoms you are experiencing?

4. When did the symptoms start?

5. Was there anything else happening when the symptoms started?

6. Have the symptoms changed since they first started?

7. What made you decide to seek help at this time?

8. Is there any current crisis or situation that needs immediate attention?

9. What medications are you taking? What effects (positive or negative) have they had? How do you feel about them?

10. Describe any previous therapy you've had, including the purpose, length, and whether you felt it was helpful. What did you like or dislike about the experience? Why was the counseling stopped? Was there anything disappointing or not addressed?

11. Tell me about your present significant relationships, including friends, family, and relatives:

12. Describe your current work, school, and living situation:

13. What are some of the successes and strengths you have experienced in your life?

14. How would you know if therapy is successful?

15. What would happen if therapy is successful? Would there be a downside? Would anyone in your life have a problem with that?

16. Who really cared about you during your childhood, adolescence, and adult years? (Friends, mentors, or family members). How did that feel? Where there any subsequent disappointments?

17. Briefly describe your school experiences, including teachers and peers. What was positive and negative about that experience?

18. Please describe any hobbies or activities (including yoga, exercise, meditation, eating, alcohol or drug use, etc.) that you use to comfort yourself:

19. If you are coming here for therapy as a couple, please describe:

- How you met:

- Two or three qualities that attracted you when you first met your partner:

- Any issues or situations in which you feel “stuck” as a couple:

Chemical use

1. How many cups of regular coffee do you drink each day?_____How many cups of tea? _____

How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? ____

How many “energy drinks”?_____How often do you use No Doz or similar caffeine pills?_____.

2. How much tobacco do you smoke or chew each week? _____

3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

6. Have you ever taken a morning “eye-opener”? ❑ No ❑ Yes

7. How much beer,wine,or hard liquor do you consume each week,on the average?_____

8. Are there times when you drink to unconsciousness,or run out of money as a result of drinking?

❑ No ❑ Yes

Please provide details about your use of any other drugs, chemicals, such as amounts, how often you use them, how you feel about your use of them, their effects, and so forth:

Please identify any of the listed situations you have experienced by rating any negative emotional impact it may have for you now. If there is more than one event in a category an age level just give a number rating to only the most distressing event, then put a check mark next to it to indicate there are others.

0 1 2 3 4 5 6 7 8 9 10
No Impact Mild Moderate Substantial Extreme

Event	0-6 years	7-12	13-17	Adult military	Adult civilian
Accident or Disaster (such as car accident where you were terrified or seriously hurt; flood, tornado, hurricane, bombing					
Military Combat (any exposure)					
Sexual abuse or rape (Someone attempting or engage in unwanted sex acts. Someone touching, you recognize as wrong.)					
Physical abuse/assault (Someone threatening, hitting, or otherwise physically attacking you.)					
Prejudice/racism (Incident in which you were affected by racial, gender, ethnic, or other prejudicial decision or behavior)					
Active or Indirect Emotional Abuse (someone verbally abusing, neglecting or abandoning you, leading to danger)					
Extensive medical treatment (Operation or medical procedures that were traumatic or frightening)					
Death of someone close because of accident, homicide, suicide, or other unnatural causes, or death of someone close by natural causes that was traumatic.					

Event	0-6 years	7-12	13-17	Adult military	Adult civilian
Extreme traumatic loss (Loss of relationship,including divorce or job etc., or traumatic betrayal.)					
Other lasting painful experience (Including something others may not consider traumatic)					
An event or activity for which you blame yourself, or others blame you, for causing trauma.					

H. Legal history

1. Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain:

2. Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes,please explain:

3. Are you required by a court, the police, or a probation/parole officer to have this appointment?
❑ No ❑ Yes. If yes, please explain:

6. Are there any other legal involvements I should know about?

Is there anything else that you feel would be important for me to know that would help my understanding of your situation?