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Client Questionnaire

Name: _____ Date: _____

REFERRED BY:

Name: _____ Phone #: _____

Address: _____

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

_____

Your Signature

CONFIDENTIALITY STATEMENT:
Case records are strictly confidential. No outsider, not even your closest relative or family doctor is permitted to see your case record without your written permission or a court order.

GENERAL

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Fax: _____ E-Mail: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

Education: _____

Occupation: _____

Currently Working: _____

What is your present job situation? _____

What is your present living situation? _____

_____

Name and ages of children

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

State in your own words the nature and history of your chief complaint:

_____

_____

_____

Present interests, hobbies, activities:

_____

_____

FAMILY HISTORY

Father's Name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

Mother's Name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

Name and ages of siblings

Name: _____ Age: ____ Name: _____ Age: ____

Name: _____ Age: ____ Name: _____ Age: ____

Name: _____ Age: ____ Name: _____ Age: ____

MEDICAL HISTORY

Past Medical History

Have you had any of these childhood illnesses?

	NO	YES	DON'T KNOW
Measles	_____	_____	_____
Mumps	_____	_____	_____
Whooping Cough	_____	_____	_____
Chicken Pox	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Rubella (German Measles)	_____	_____	_____

Please list medical hospitalizations and operations. Give diagnoses and dates:

_____

_____

_____

Have you ever suffered from any of the following illnesses?

	NO	YES	DATE OF ONSET
Cancer	_____	_____	_____
T.B	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid Trouble	_____	_____	_____
Kidney Trouble	_____	_____	_____
High Blood Pressure	_____	_____	_____
Eye Trouble	_____	_____	_____
Heart Trouble	_____	_____	_____
Neurological Disease	_____	_____	_____
Ulcers	_____	_____	_____
Head Injury	_____	_____	_____
D.T.'s	_____	_____	_____
Allergies	_____	_____	_____

List all Allergies: _____

_____

Any other serious illnesses?

_____

Name of Physician: _____ Phone number: _____

Date of last physical examination: _____

Drug/Medication History

Because many drugs (legal and illegal) have psychological effects, it is important for me to know what drugs you are currently taking and/or have taken in the past. This information will remain strictly confidential, but it is very important for me to know before you begin therapy so that an accurate assessment of your problem and situation can be made. Please list all legally prescribed and illegal drugs ever used (past or present) and describe how often you use them and what effects you seek:

_____

_____

_____

_____

_____

Have any of these drugs been prescribed by a physician?

Yes __ No __ If so, which drugs and for what reason?

_____

Symptoms

Check any of the following symptoms which apply to you at this time. Also indicate when any of these symptoms have applied to you in the past.

Falling Hair	_____	Fainting Spells	_____
Weight Gain	_____	Difficulty Sleeping	_____
Fatigue	_____	Drinking too much Fluid	_____
Constipation	_____	Blurred Vision	_____
Dry Skin	_____	Deafness	_____
Weakness	_____	Ringing in Ears	_____
Weight Loss	_____	Chest Pain	_____
Tremor	_____	Shortness of Breath	_____
Big Appetite	_____	Tingling of Hands or Feet	_____
Fast Heart Beat	_____	Ankle Swelling	_____
Diarrhea	_____	Indigestion	_____
Poor Appetite	_____	Nausea or Vomiting	_____
Headaches	_____	Urinary Difficulties	_____
Dizziness	_____	Problems with Sexual Organs	_____

Smoking and Drinking

Do you smoke (anything)? _____ What? _____ How much? _____ Frequency? _____

Do you drink alcohol? _____ If yes, how much? _____

What happens to you when you smoke or drink, that is, what does it do for you?

_____

_____

Describe any physical symptoms at all that you have when you smoke or drink.

_____

_____

What kind, and how much physical exercise do you get?

_____

_____

_____

Describe the spiritual/religious aspects of your life:

_____

_____

_____

_____

Have you ever been on Worker's Comp or Disability. For what, how long, results?

_____

_____

_____

_____

Name of your Insurance Company _____

Policy Number: _____ Soc. Sec. No: _____

Previous Medical, Psychiatric and Psychotherapy Contacts

Have you ever been in psychotherapy before? _____

If yes, when? _____

May I contact your previous therapist(s)? _____

Therapist: _____

Address: _____

Phone#: _____

Therapist: _____

Address: _____

Phone#: _____

Have you ever been hospitalized for an emotional problem?

If yes, when, where, and how long? _____

_____

If yes, when, where, and how long? _____

_____

Have you ever made a suicide attempt?
If yes, describe it, when, and the circumstances leading up to the attempt.

_____

_____

_____

Give a brief history of any litigation you have been involved in regarding child custody, divorce, liability, or medical malpractice.

_____

_____

_____

Is there any other information about you that you think would be important or helpful for me to know?

_____

_____

_____

_____

In case of emergency, please notify one of the following three people:
May I have your permission to inform one or all of these people if you are ever in danger?

Yes _____ No _____

1. _____
Name | Daytime Phone | Evening Phone | Address

2. _____
Name | Daytime Phone | Evening Phone | Address

3. _____
Name | Daytime Phone | Evening Phone | Address

_____ _____
Your Signature Date

_____ _____
Therapist's Signature Date