Client History Questionnaire

The purpose of this questionnaire is to obtain as comprehensive a picture of you and your background as possible. It will be invaluable as we determine a direction and plan for treatment, and I hope you will consider the time you spend completing it an investment in your future well-being. These case records are ***strictly confidential***, no one has access to information about you without your express, written consent. Information gathered through the use of this form will be diligently respected and protected.

Name: _____

Address: _____

Telephone: (cell) (_____)_____-_____ (home) (_____)_____-_____ OK to call _____

Age: _____ Occupation: _____ Sex M F

Birthdate:_____ By whom were you referred? _____

Emergency Contact: _____ Relation: _____

Emergency Contact phone number: _____

Marital Status: Single Married Separated Divorced Widowed Long Term Relationship

Description of presenting problem(s):

_____

_____

_____

_____

_____

On the scale below please estimate the severity of your problem(s):

__|_____|_____|_____|_____|_____|____

Mildly Upsetting	Moderately Upsetting	Severe	Extremely Severe	Totally Incapacitating

When did this difficulty begin: _____

_____

How is this problem affecting your current life?: _____

_____

What have you tried to remedy this problem? _____

_____

Problem Checklist

Please circle any of the following that you have experienced in the past three months.

Depression	Tearfulness	Feeling Lonely
Feeling Sad	Mood Swings	Body Image issues
Avoiding Friends	Eating More	Eating Less
Weight Change	Excessive Energy	Decreased Interest in Sex
Sexual Difficulties	Tired	Decreased Interest in Usual Activities
Sleeping More	Sleeping Less	Nightmares
Sleepwalking	Headaches	Stomachaches
Difficulty Concentrating	Easily Distracted	Disorganized
Impulsive	Hearing Things Others Don't	Seeing Things Others Don't
Anxious	Excessive Worry	Panic Attacks
Low Self-Esteem	Arguing	Obsessive/Ritualistic Behaviors
Irritable	Defiant/Conduct	Angry
Easily Frustrated	Self-Injury	Suicidal Thoughts
Suicidal Plans	Homicidal Thoughts	Difficulty in Social Relationships
Eating Disorder	Marital Issues	Abuse

Past Experiences linked to symptoms: _____

_____

_____

Strengths

What are some special talents or skills that you feel proud of? _____

_____

How do you usually cope with difficult situations/emotions/thoughts?: _____

_____

Educational History:

What is the last grade completed (degree): _____

Course of Study: _____

Medical:

Medical Doctor: _____

Telephone & fax: _____

Are you currently receiving treatment for any physical problem? If yes, please explain: _____

_____

Do you have any other physical health issues? Yes No If yes, please explain:_____

_____

List any Disabilities _____

Please list **all** medications. Include prescriptions and over-the-counter drugs, as well as nutritional supplements. Use a separate sheet if necessary:

Name Dose Frequency Prescribed By

_____

_____

_____

_____

_____

Do you consume alcohol? Y N _____ Drinks per day _____ Drinks per week

Do you use recreational drugs? Y N Type/Amt/Frequency _____

List any other addictions (e.g., food, cigarettes, internet pornography, gambling)._____

Legal History:

Have you ever had legal difficulties/problems? Yes No If yes, please explain: _____

_____

Do you have any pending charges? Yes No If yes, please explain: _____

_____

Are you currently on probation/parole? Yes No If yes, please explain: _____

_____

Any other information concerning legal issues? _____

Employment History:

Current employer _____

How long have you been employed here? _____ Title: _____

Relationship with colleagues and employer: Poor Fair Good Very Good Excellent

Are you satisfied with this position/employment: Yes No

Past employment, types of jobs: _____

_____

Military: Yes No If yes, give dates and discharge status: _____

Are finances a source of distress for you? If yes, please explain: _____

_____

_____

Personal History:

Place of birth _____

Siblings: Number of Brothers _____ Brothers Ages _____

Number of Sisters _____ Sisters Ages _____

Father: If living, present age ____ If deceased, age at time of death ____ Your age at the time? ____

Occupation _____ Health _____

Cause of death, if applicable _____

Mother: If living, present age ____ If deceased, age at time of death ____ Your age at the time? ____

Occupation _____ Health _____

Cause of death, if applicable _____

Religion: As a child: _____ As an adult _____

What religion or spiritual concept do you currently practice or have belief in? _____

_____

Have you ever been involved in any cult activities? Yes No

Where were you raised? _____

What is the ethnic/cultural background of your family: _____

Primary language: _____ Other languages: _____

Circle any of the following that applied during your childhood/adolescence

Happy Childhood	School Problems	Medical Problems	Unhappy Childhood
Family Problems	Alcohol Abuse	Emotional/Behavior Problems	Drug Abuse
Strong Religion	Legal Problems	Other:	

Were there any traumatic events (deaths, family violence, relocations, natural disasters, etc.) during your childhood and adolescence? If yes, please describe: _____

_____

_____

Do any of your close family members have medical/psychological/developmental difficulties? If yes, please explain: _____

_____

_____

Current Living Situation (Type of Home/Who do you live with): _____

_____

Children - # of Biological _____ # of Step _____ # of Adopted _____ # of children in Home _____

How do you spend your free time? _____

_____

Interpersonal History:

If currently in a relationship, with whom? _____

How long have you been in this relationship? _____

Describe any significant events/issues in this current relationship: _____

_____

_____

Who are the most important people in your life? _____

_____

Who is supportive of you? _____

Do you make friends easily? Yes No Do you keep friends? Yes No

Psychiatric/Psychological History:

I have experienced:

Physical abuse	Emotional abuse	Sexual abuse
Psychological abuse	Verbal abuse	Neglect (emotional/physical)

Have you ever thought about or attempted suicide? Yes No If yes, please explain: _____

_____

_____

What was going on in your life at that time? _____

_____

Has any family member ever attempted or completed suicide? Yes No If yes, please describe:

_____

Have you previously received psychological services? Yes No If yes, please provide a brief description of the experience, the time frame, and the name of the provider(s):

_____

_____

_____

Have you ever been hospitalized for a psychological/psychiatric problem? Yes No If yes, please describe the circumstances, name of the treating physician/therapist, hospital and dates:

_____

_____

Current Goals for Treatment: _____

_____

_____

Is there anything you would like to share with me, or ask, that hasn't been addressed in this questionnaire?

_____

_____

_____

_____ _____

Signature Date