

Confidential Client Information

The purpose of this questionnaire is to obtain a comprehensive picture of your background. In scientific work, records are necessary since they permit a more thorough dealing with one's problems. By completing these questions as fully and as accurately as you can, you will facilitate your therapeutic program. You are requested to answer these routine questions on your own time instead of using your actual consulting time. If more space is needed, add another piece of paper. If you do not wish to answer any questions, write "Skip."

I. PERSONAL IDENTIFICATION

Name _____ Birthdate ___/___/___ Age ____
(First) (Middle) (Last)

Address

(Street) (City) (State) (Zip)

Phone: Home (____) _____ Work (____) _____ Other (____) _____

Circle number at which a message may be left.

Marital Status: Single Married Widowed Separated Divorced Remarried

If divorced/separated/remarried, give names of spouse(s) and dates:

Emergency Contact _____ Phone (____) _____

Address _____
(Street) (City) (State)(Zip)

Relationship _____

II. PROBLEM(S) FOR WHICH YOU ARE SEEKING ASSISTANCE

(List and describe as well as you can)

1. _____

2. _____

3. _____

III. EDUCATION

Highest grade completed or degrees held _____

Vocational training _____

Are you planning on continuing your education? _____

IV. EMPLOYMENT

Current occupation/position _____ Part/Full Time _____

How Long? _____ Employer _____

(Street) (City) (State) (Zip) () (Phone)

Your duties _____

Previous employment (if any) _____

Describe relationship with people at work

V. MILITARY SERVICE (if applicable)

Branch _____ Dates of Service _____

Type of discharge _____ Rank _____ Combat experience? _____

VI. RELIGION

Do you consider yourself a religious person? _____ Which? _____

VII. LEISURE

Hobbies or Interests

What others would you like to pursue _____

Explain whether you make good use of your time or not. _____

Describe relationship with friends and neighbors

VIII. PHYSICAL HEALTH HISTORY

Present: Excellent Good Average Poor

Current illnesses and symptoms _____

Past surgery, accidents and/or handicaps and dates of these

Have you noticed any recent changes in:

sleeping patterns eating patterns physical activity

increased tension/nervousness behavior energy

weight disposition

Describe _____

Have you, your parents, grandparents, brothers, or sisters been treated for

	Self	Other (specify)	Dates from	
Allergies	_____	_____	_____	to _____
Anxiety	_____	_____	_____	to _____
Asthma	_____	_____	_____	to _____
Broken bones	_____	_____	_____	to _____
Cancer	_____	_____	_____	to _____
Depression	_____	_____	_____	to _____
Diabetes	_____	_____	_____	to _____
Fainting/Dizziness	_____	_____	_____	to _____
Hearing	_____	_____	_____	to _____
Heart Disease	_____	_____	_____	to _____
High/low blood pressure	_____	_____	_____	to _____
High/low blood sugar	_____	_____	_____	to _____
Nervous Breakdown	_____	_____	_____	to _____
Nutritional Problems	_____	_____	_____	to _____
Sexually Transmitted Disease	_____	_____	_____	to _____
Thyroid	_____	_____	_____	to _____
Ulcer/stomach problems	_____	_____	_____	to _____
Vision	_____	_____	_____	to _____
Other	_____	_____	_____	to _____

Physician _____ Address _____

Phone () _____

Date of last physical _____ Results _____

Current medication and dosage _____

Past medications _____

IX. LEGAL INFORMATION

Currently involved in any active cases (traffic, civil, criminal) Yes No If yes, describe _____

Presently on probation or parole Yes No If yes, describe _____

Past history	Yes	No	Describe
Traffic violations (other than parking)			_____
Civil involvement			_____
Criminal involvement			_____

X. MENTAL HEALTH

Type and dates of past emotional difficulties _____

Prior treatment for above (note place, type of treatment and therapist)

With whom: _____

Address: _____

Phone: _____ Dates: _____

List any situations in which you feel particularly anxious _____

List any methods you use to relax or calm yourself _____

Have you ever lost control (temper, crying, aggression)? If so, please explain.

Hospitalizations From _____ to _____ Where _____

UNDERLINE any of the following words that apply to you:

worthless, useless, a "nobody," empty, inadequate, stupid, incompetent, naive, "can't do anything right," guilty, evil, immoral, horrible thoughts, hostile, angry, anxious, agitated, cowardly, unassertive, panicky, ugly, depressed, aggressive, deformed, unattractive, repulsive, lonely, unloved, bored, misunderstood, restless, confused, unconfident, in conflict, full of regrets, overwhelmed, stressed, confident, worthwhile, sympathetic, intelligent, attractive, considerate, hard working, loyal, organized, compassionate, talented

Other:

XI. SUBSTANCE USE HISTORY

Date of last drink _____

Type of drink	Beer	Wine	Liquor
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Number of each	_____	_____	_____
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Do you regularly use alcohol?	Yes	No
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How old were you when you first started to drink regularly? _____

Do you use other substances?	Yes	No
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If yes, please specify which and frequency: _____

Has drinking or drug use ever caused problems for you? ____ If yes, please elaborate.

Have members of your family experienced difficulty with alcohol or drugs? ____ If yes, please describe. _____

List substances used in last 48 hours. _____

Have you ever experienced an overdose, withdrawal, or adverse alcohol, drug or medication reaction? ____ If yes, describe circumstances _____

Have you ever been treated for the above? ____ Describe. _____

XII. PERSONAL FAMILY (If applicable or if you are living with someone.)

Spouse's name _____ Age ____ Years married ____

How long have you known this person? _____

Describe personality in your own words: _____

Areas of compatibility _____

Areas of incompatibility _____

Relationship with in-laws:

Children's names, sex, ages, and personality. Check box if living in your home.

Name	Sex	Age	Personality	Living in home
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Does one child present a special problem? ____ Explain. _____

Give details of any previous marriage(s) _____

XIII. FAMILY OF ORIGIN

Father _____ Age _____
(or age at and date of death, cause)

Occupation _____ Highest grade completed _____

Mother _____ Age _____
(or age at and date of death, cause)

Occupation _____ Highest grade completed _____

Brother's Names and Ages

Sister's Names and Ages _____

Describe relationship with mother and father (past and present) _____

Describe relationship with brothers and sisters (past and present) _____

List family member(s) who have had counseling, substance abuse or psychiatric services.

Give a brief description of your father's personality and his attitude toward you (past and present)

Give a brief description of your mother's personality and her attitude toward you (past and present)

How were you punished as a child?

Give an impression of the home atmosphere in which you grew up. How compatible were your parents with each other? With the children? _____

Were you able to confide in your parents? _____

If you had a step-parent, give age when your parent remarried. _____

Give a brief description of your religious training. _____

If you were not brought up by your parents, who did and between what ages?

Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc.?

Who are the most important people in your life, in terms of influence, impact, etc.?

XIV. SEXUAL INFORMATION

Are there any particular sexual issues that concern you? _____

XV. Is there anything else you think I should know about you?

Signature of person completing form

Date