Today's Date: ________________

CLIENT QUESTIONNAIRE

Information About You:

First Name:		**Middle:**		**Last Name:**
Phone Numbers:	**Home:** ❑ *OK to call* ❑ *OK to leave message*	**Cell:** ❑ *OK to call* ❑ *OK to leave message*		**Work:** ❑ *OK to call* ❑ *OK to leave message*
Is there anything I need to know about contacting you at these numbers?				
Street Address:				
City:		**State:**		**Zip Code:**
Email:	**Ok to use? Yes/No**		**Date of Birth** *(mm/dd/yy)*:	

PRIMARY INSURANCE COVERAGE

Insurance Company: ______________________________ **Subscriber:** ___________________________________

Insured's Employer Name: _________________________ **Subscriber's Date of Birth:** ______________________

SECONDARY INSURANCE COVERAGE

Insurance Company: ______________________________ **Subscriber:** ___________________________________

Insured's Employer Name: _________________________ **Subscriber's Date of Birth:** ______________________

Emergency Contact Name:	**Relationship to You:**
Emergency Contact Phone Number(s):	
Health Care Providers' Name(s)/Phone Number(s):	
Physical Health: **Impact of physical/medical concerns on you and/or those around you?**	
Current Medications:	

Work/Career Situation:

Partnership Status:

Children/siblings (include biological, adopted, foster, step, etc.):

Name	Sex	Age	Type (biological, step, adopted, etc.	Living with you?

Does anyone else live with you?

History: How often did you experience the following in your emotional environment growing up?

	Never		Sometimes		Always
Warm connected relationships	❑	❑	❑	❑	❑
Volatile, angry outbursts	❑	❑	❑	❑	❑
Punitive judgmental attitude	❑	❑	❑	❑	❑
Reasonable rules and limits	❑	❑	❑	❑	❑
Rigid, repressive limits	❑	❑	❑	❑	❑
Chaos, not enough structure	❑	❑	❑	❑	❑
Abusive, destructive relationships	❑	❑	❑	❑	❑
Addictive behavior:					
Alcohol	❑	❑	❑	❑	❑
Sex	❑	❑	❑	❑	❑
Food	❑	❑	❑	❑	❑
Drugs	❑	❑	❑	❑	❑
Spending	❑	❑	❑	❑	❑

What is your current emotional support system like? Family, friends, spiritual support, etc.?

At what age did you first experience sexual touching?

Is there anything in your sexual history that disturbs or concerns you?

Are you currently or have you ever been in a relationship where you were hurt, threatened, insulted or felt afraid either physically or emotionally?

Have you behaved in this way toward anyone else?

Have you at any time in your life been concerned about your use of alcohol or other drugs, including prescription medication and supplements?

Has anyone ever expressed concern about your use?

How do you feel on a normal day? ***(please check all that apply)***

□ Depressed	□ Worried	□ Sad
_ Anxious	□ Frightened	□ Grieving
_ Confused	□ Loving	□ Alone
_ Happy	□ Guilty	□ Lost
_ Successful	□ Tired	□ Relaxed
_ Angry	□ Burned out	_ Hopeful
_ Content	_ Shy	_ Other ______________________________

Are you experiencing any difficulties in the following areas: ***(please check all that apply***)

□ Alertness	□ Depression/Sadness	□ Pain management
□ Appetite	□ Dizziness/Faintness	□ Sexual problems
□ Body image concerns	□ Headaches	□ Sleep
□ Breathing	□ Memory	□ Stomach pains
□ Concentration	□ Nightmares	□ Stress management/Anxiety
□ Conflict in current relationship	□ Numbness	□ Weight loss or gain

In your life, have you ever felt suicidal? When?

Have you seen a counselor/therapist in the past? □ Y □ N ***(if yes, please provide the name or agency)***	**Are you currently seeing another counselor/therapist? □ Y □ N** ***(if yes, please provide the name/agency and phone no.)***

If you have been in counseling or therapy in the past, what was helpful? What was not helpful?

Please describe your reason for seeking counseling at this time.

Hopes and goals for personal growth or change? Relationship growth/change?

What are your thoughts about how I might be of help?

Is there anything that you would like me to know that I have not asked?