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**New Client Questionnaire**

Welcome! Thank you for taking a few minutes to fill out this form. The information you provide is confidential. If you have any questions, please let me know.

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number (Primary) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number (Secondary)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we send texts to confirm and/or change Appointment times? Yes \_\_\_\_ or No \_\_\_\_\_

May we leave a voice message? Yes \_\_\_\_ or No \_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we use email to contact you? Yes \_\_\_\_ or No \_\_\_\_\_

Emergency Contact (Name, Relationship, Address, Phone number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Closest Relationships:

Name Age Relationship Living with You?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe who lives with you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you participated in therapy before? Yes \_\_\_\_ or No \_\_\_\_\_

If Yes, When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently seeing a psychiatrist, therapist, or other helper? Yes \_\_\_\_ or No \_\_\_\_\_

Have you or a family member ever been hospitalized for a mental illness? Yes \_\_\_or No \_\_\_\_

If yes, please explain (Date, Location, Reason) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance Abuse History Yes \_\_\_\_ or No \_\_\_\_\_

Legal History (Parking Tickets, Arrests, Convictions, DWIs, ect.) Yes \_\_\_\_ or No \_\_\_\_\_

DHS/Protective Service Involvement Yes \_\_\_\_ or No \_\_\_\_\_ If yes, please explain:

MEDICAL INFORMATION

Physician’s Name and Contact Information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major Medical Conditions/Concerns \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you enter psychological treatment with me, may I be in contact with your medical doctor in effort to coordinate care and so that he or she can be fully informed. Yes \_\_\_\_ (ROI Signed) or No \_\_\_

How can I help? Tell ME in your own words what brings you here today?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are your two most important goals in counseling?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Below is a list of common problems or concerns. Please rate how you believe these effect you, if applicable, using the following scale:

0= None 1= Mild 2= Moderate 3= Severe

Anxiety \_\_\_ Abused as a child \_\_\_ Alcohol/Drugs \_\_\_ Addiction \_\_\_

Anger \_\_\_ Appetite \_\_\_ Being a Parent \_\_\_ Aging \_\_\_

Children \_\_\_ Career Choices \_\_\_ Concentration \_\_\_ Confidence \_\_\_

Communication \_\_\_ Compulsions \_\_\_ Child Custody \_\_\_ Depression \_\_\_

Codependency \_\_\_ Divorce/Separation \_\_\_ Disability \_\_\_ Education \_\_\_

Eating Problem \_\_\_ Energy \_\_\_ (high/low) Fatigue \_\_\_ Family \_\_\_

Fears \_\_\_ Friends \_\_\_ Guilt \_\_\_ Headaches \_\_\_

Gender identity \_\_\_ Greif/Loss \_\_\_ Faith/Religion \_\_\_ Intimacy \_\_\_

In-laws \_\_\_ Insomnia \_\_\_ Marriage \_\_\_ Loneliness \_\_\_

Making Decisions \_\_\_ Mood Swings \_\_\_ Money/Debt \_\_\_ Memory \_\_\_

Nervousness \_\_\_ Nightmares \_\_\_ Panic Attacks \_\_\_ Parents \_\_\_

Past Hurts \_\_\_ Painful thoughts \_\_\_ Phobias \_\_\_ Sleep \_\_\_

Self Esteem \_\_\_ Separation \_\_\_ Relationships \_\_\_ Short Temper \_\_\_

Suicidal Thoughts \_\_\_ Stress \_\_\_ School \_\_\_ Work \_\_\_ Worries \_\_\_