Date: _____

Client Information and Questionnaire

Name: _____ Birth date: _____

Address: _____ City: _____Zip: _____

Telephone Numbers: _____e-mail: _____

Insurance Carrier: _____

Name and birth date of policyholder (if not client): _____

This section for office to complete:

PPO/HMO (circle one)

Authorization required?_____

Authorization number_____

ID Number: _____

Group Number: _____

Provider phone Number: _____

Effective date: _____

Deductible: _____

Copay/Coinsurance: _____

Limit in number of sessions per year_____

Diagnosis code_____

Patient Control Number (billing purposes)_____

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Referral Source: _____

Reason for seeking therapy now:
_____
_____
_____

Occupation: _____

Marital Status: ____ Single ____ Engaged ____ Married ____ Partnership
____ Separated ____ Divorced ____ Widowed

Number of Children (names and ages):_____
_____

Emergency contact (name, phone number and relationship to client):_____
_____

Health Information

Do you have any current medical concerns? _____
_____

Do you currently take any medications? _____
_____

Internal/Family Medical Care Provider: _____
_____

Current or past psychiatric diagnoses: _____
_____

Safety History:

Have you ever thought of hurting or killing yourself or others? If yes, please explain.

Have you ever acted on it? If yes, briefly describe and include dates.

Are you currently having thoughts of hurting yourself or others? Please explain.

Mental Health History:

Are you currently or have you ever received counseling/therapy? Yes No

Outpatient (reason and dates):

Inpatient (reason and dates):

Previous Medications:

Childhood History: (If yes, please elaborate)

Did anyone verbally abuse you?

Did anyone hit or physically abuse you?

Did anyone sexually abuse you or touch you in a way that felt bad to you?

Did someone close to you die? (Whom and at what age?)

Adult Experiences: (If yes, please elaborate)

Has anyone hit you as an adult?

Has anyone raped you or forced you to have sex when you did not want to?

Personal History:

List other important information about the following: your support systems, family history, cultural background, history of losses, significant childhood events, religion and spirituality.

Strengths: List your character and personality strengths.

Goals: What do you want to accomplish while in counseling; changes you want to make in yourself, issues to resolve:

Problem Checklist (check all that apply)

Depression

Chronic sadness
Crying episodes
Hopelessness
Difficulty concentrating
Weight loss
Weight gain
Loss of appetite
Emotional eating
Nausea/vomiting
Difficulty making decisions
Recurring thoughts of death/dying
low frustration tolerance
irritability
sleep disturbances
memory issues
thoughts of suicide/homicide
social isolation
difficulty functioning at work
difficulty functioning socially
low energy/fatigue
reduced interest/pleasure
feelings of worthlessness/guilt

Anxiety

Agitation
Restlessness
Excessive worry
Fearfulness
Trembling/shaking
Fear of dying
Fear of loss of control
panic attacks
fear of leaving home
avoidance of public places
avoidance of social situations
pounding heart/shortness of breath
chest pain

Stress/Trauma

Feeling detached from life/others
Intrusive thoughts of bad memories
Nightmares
flashbacks/re-living situations
easily startled/upset
lack of restful sleep

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Thinking Problems

Hearing voices others do not hear
seeing things others do not see
Fearful others are talking about you
fearful others are plotting against you

Eating Problems

Self-induced vomiting
use of laxatives
Obsessing about food/diet/exercise
eating causing health problems

Substance Use:

What type? _____ Current/Past (circle one)

How many days per week do you use drugs/alcohol? _____
How many drinks per day? _____

What drugs do you use? _____

Have you ever received any drug or alcohol treatment (if yes, when)? _____
_____