Client Questionnaire

Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected as confidential information

Name:_____ Date: _____

Address: _____

Home Phone: ___ _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____

Please note: Email correspondence is not considered to be a confidential medium of communication.

DOB: _____ Age: _____ Gender: _____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Education (i.e, how far did you go in school?) _____

Briefly describe your reason for seeking help_____

_____

Referred By (if any): _____

Have you ever received psychological or psychiatric help or counseling of any kind before? □ Yes □ No

If yes, please explain: _____

_____

Are you currently taking any prescription medication? □ Yes □ No

If yes, please list: _____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No

If yes, please list and provide dates: _____

_____

List the people that you currently living with.

Name(s)	Age	Relationship	Occupation
_____			
_____			
_____			
_____			

Please circle any of the following problems which pertain to you:

Nervousness	Depression	Fears
Shyness	Sexual Problems	Suicidal /Homicidal Thoughts
Couple Problems	Divorce or Separation	Finances
Anger	Self-Control	Unhappiness
Sleep	Stress	Victim of Abuse
Relaxation	Headaches or Stomach Aches	Tiredness
Legal Matters	Memory	Making Decisions
Energy	Insomnia	Concentration
Loneliness	Inferiority Feelings	Health Problems
Education	Career Choices or Work	Conflicts with Parents or Siblings
Temper	Nightmares	My Thoughts
Children	Appetite or Food Problems	Anxiety

Which insurance are you using to cover all or a portion of our service? If you know the limits for mental health coverage, please indicate that as well.

Insurance Company: _____

Co-pay: _____

Person responsible for payment if other than client

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Emergency Contact:

Name_____ Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____