Client Questionnaire

Please fill in the form and bring it with you to our first meeting. The information you are providing is protected and considered confidential.

Patients Name:_____ Date of 1st appointment:_____

What are the concerns that motivated you to seek therapy?:_____

_____

_____

When did the problems begin?:_____

_____

Are they getting –better, -worse, -remain the same? (please circle)

Relationship Status (Circle): Married Single Divorced Separated Widowed Partnered
Number of children:_____ Names and ages:_____

_____

_____

Do any of them live with you now?:_____

_____

Where were you born and where did you grow up?:_____

_____

Was there any problem with your birth: _____

Developmental milestones or problems (walking, talking etc.):_____

_____

_____

Did your parents divorce:_____ How old were you?:_____

Number of siblings (indicate biological-, step-, brothers-, sisters-):_____

_____

_____

Are you the Oldest, Youngest, Middle or Only child? (Circle)

How would you describe your childhood?: Good Bad Traumatic Happy Sad Lonely Scary

_____

As a child, did you ever suffer from Physical, Sexual, Verbal or Mental abuse? (Please briefly explain- who, what, how old were you…)_____

_____

_____

Education- what is the highest level of education you received?_____

If you did not finish High school, briefly explain why_____

_____

Have you ever been in special education classes? _____or repeat a grade?_____

Were you ever diagnosed with a Learning Disability or ADD/ADHD?_____

_____

If not diagnosed, do you find that you have had difficulties? Please describe_____

_____

Are you currently working?_____, for how long at this job?_____

Do you enjoy your work? Are you experiencing stress? Please describe: _____

_____

If you are not working, what is the reason, please describe briefly?:_____

_____

Did you serve in the armed forces?_____ Dates_____ Highest Rank:_____

Any Combat experience (when, where)?_____

Do you have a Disability that is related to your service, please describe?_____

_____

Legal History: Have you ever been arrested or involved in a case litigation? Please explain:

_____

_____

Are you or do you have a history of drug or alcohol abuse? If yes, please describe, time, what, how long/often _____

_____

Any treatment?_____

_____

Do you have any chronic medical issues? Please list_____

_____

Do you have chronic physical pain, where?_____

_____

Circle the number that describes your pain level on MOST days 0 1 2 3 4 5 6 7 8 9 10

Have you ever been in Psychiatric care?_____ Diagnosis:_____

Were you ever hospitalized for emotional issues? What were the reasons? Please circle:

Depression Suicidal Ideas Anxiety Manic Other_____

Name of current Psychiatrist:_____

Have you been in therapy before, when ?_____ How long ?_____

Name of previous Therapist:_____

Please list all medication you are currently taking, Names and dosage:_____

_____

_____

_____

How do you experience your daily activities?_____

_____

What do you do for fun (Hobbies, Interests..)?:_____

_____

Describe your Faith/spiritual believes?:_____

_____Affiliation?_____

Please list your sources of support and strength in your life:_____

_____

_____

What would you like to achieve in your therapy?_____

_____

_____

Additional relevant information you would like to share:

_____ _____

Signature Date