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CLIENT INFORMATION

Your cooperation in completing this questionnaire will be helpful in planning my services to you. Please answer each item carefully or ask for clarification if you do not understand an item.

Clients
Full Name:_____Today's Date:_____

Address:_____
Street City

_____
State Zip Code

Telephone:_____
(home) (work) (cell) (email)

Age: _____Date of Birth:_____ Marital Status:_____

Occupation:_____

Employer:_____

Education:_____

Spouse (or significant other)
Name:_____Date of birth:_____Age:_____

Occupation:_____ Employer:_____

Telephone:_____
(work) (cell)

If client is a minor:

School:_____Grade:_____

Father's Name:_____Mother's Name:_____

Father;s Address:_____Mother's Address:_____

_____ _____

Father's Phone:_____ Mother's Phone:_____
(home) (home)

_____ _____
(work) (work)

If parents of minor child are separated or divorce, please describe living arrangements and decision-making Arrangements (Custody):_____

Parental Access Schedule:_____

Briefly describe your reasons for seeking help:_____

Who referred you?:_____

When was client last examined by a physician?:_____

List any major health problems for which client currently receives treatment:_____

List any medications currently being taken:_____

Has client ever received psychiatric or psychological help or counseling of any kind?_____

If so, please explain:_____

Has there been any history of:

Violence_____, Sexual Abuse_____, Suicidal Thinking_____, Suicide Attempts_____

Drug use_____, Alcohol use_____

If so, please explain:_____

Please circle any of the following which pertains to client.

Nervousness	Depression	Fears	Shyness
Sexual Problems	Suicidal thoughts	Separation	Divorce
Anxiety	Drug use	Alcohol use	Friends
Anger	Self-control	Unhappiness	Sleep
Stress	Work or school	Relaxation	Headaches
Tiredness	Legal matters	Memory	Ambition
Energy	Insomnia	Making decisions	Violence
Loneliness	Inferiority feelings	Concentration	Education
Career choices	Health problems	Intimacy	Temper
Nightmares	Marriage	Bowel Problems	Being a parent

List the members of your family and all others living in your home:

Name(s)	Age/Birth Date	Relationship	Occupation/Grade

Please add any additional information which you feel may be useful for me:

_____

Your signature

Thank you for completing this questionnaire.