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NAME:_____

DATE: _____

CLIENT QUESTIONNAIRE

Please state why you are seeking counseling services: _____

_____

_____

Have you recently experienced the following?
0 – none 1 – mild 2 – moderate 3 - severe

	0	1	2	3	
Memory Problems _____					
Anxiety_____					
Depression_____					
Suicidal thoughts _____					
Homicidal thoughts/intent to harm_____					
Anger _____					
Fear _____					
Unwanted thoughts _____					
Worrying _____					
Change in weight_____					
Eating difficulties _____					
Sleep difficulties_____					
Difficulty concentrating_____					
Racing thoughts_____					
Low energy _____					
Other _____					

Have you or a family member experienced the following?
PLEASE CHECK

	Self	Family Member
Fever, breathing problems & night sweats _____		
Thyroid problems _____		
Premenstrual syndrome _____		
Menopausal syndrome _____		
Alcoholism _____		
Drug addiction_____		
Mental illness _____		
Suicide (or attempts)_____		
Hospitalization for mental health_____		
Hospitalization for physical illness _____		
Physical abuse _____		
Sexual abuse _____		
Recent death of someone close _____		
Domestic violence_____		
Physical pain_____		
Other_____		

How would you rate the overall severity of the symptoms you have noted above? (circle one)

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Severe Moderate Mild

How would you rate your overall functioning? (circle one)

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Unable to function in All areas | Unable to function in most areas | Serious difficulty functioning | Mild to moderate difficulty | Minimal difficulty | No Difficulty

Current medical/physical conditions: _____

Symptoms are Same____Better____Worse____ When did they change? _____

Are you receiving medical treatment for your condition or symptoms? Yes___No___ By whom: _____

Date of latest medical exam:_____ With Whom:_____Reason: _____

Recent hospitalization? Yes___No___ Reason:_____

SEE NEXT PAGE

Name:_____ Case #:_____

Please list any prescription or non-prescription medications you are presently taking:

Medication	Dosage	Purpose	Prescriber

Amount of coffee, tea, or soda pop you drink each day:_____

Do you use:	Yes	No	How often?	Amount (number of cigarettes, drinks, grams, etc.)	Have you ever been treated for addiction?
Cigarettes or chewing tobacco?					
Alcohol?					
Any drugs? Types:					

Has your alcohol or drug use changed recently? Yes ___No___ If yes, in what way? _____

Have you ever been treated for alcohol or drug addiction? Yes ___No___ If yes, when?_____

Type of Treatment (inpatient, outpatient, AA, etc.): _____

Are you having thoughts of harming yourself? Yes____ No ____

Have you ever attempted suicide? Yes No If so, when was your last attempt? _____

Did you ever need to be hospitalized for a mental health issue? Yes No

If so, please describe when and what the reason was: _____
_____

Please mark if you experienced the following in any of your intimate partner relationships:

☐ Verbal abuse ☐ Emotional abuse ☐ Physical Abuse ☐ Psychological Abuse ☐ Humiliation
☐ Limited access to mutual finances ☐ Isolated from friends/family ☐ Destruction of your property
☐ Doing sexual activity you didn't want to do ☐ Intimidation with weapon ☐ Weapons were used on you
☐ Abuser made threats to harm self ☐ Parenting was impacted by abuser ☐ Unable to wear what you wanted

Is there anything else you experienced in any of your intimate partner relationships you'd like me know about right away?
_____

Is there any family history of mental illness? _____Yes _____ No
_____

Are there issues with your family of origin (family you grew up in) that you believe are influencing the quality of your life today? If so, please describe:
_____
_____

Please describe any religious/spiritual affiliation or spiritual practice (optional)
_____

Do you want to have your faith/spiritual practice integrated into therapeutic treatment? Yes No

Have you been in counseling before? Yes No

If so, what provider and when were you receiving services? _____
Previous mental health diagnosis (if known)?
_____

At the end of working together, where do you see yourself?
_____
_____

Is there anything else you'd like your therapist to know?: _____