Client Information Questionnaire

Please fill out this form as completely as possible and bring it to your next session. The information you provide will facilitate our work together. All information is confidential and will not be released except upon your written request. Use the backside of the form if you need additional room to

Your Name: _____ Today's Date:_____

Mailing Address: _____ City:_____ Zip: _____

Day Phone: _____ Evening Phone:_____Cell: _____

Best time to call? _____Your email address: _____

How did you learn of my services? ☐ My Website ☐ Internet ☐ NPA ☐ Psychology Today ☐ Another Person

Who referred you? _____ May I acknowledge the referral? ☐ Yes ☐ No

Date of Birth: _____ Current Age: _____

Education? □ Elementary □ High School □ Some College □ College Degree □ Graduate Work

Current Occupation: _____ Employed by:_____ How long? _____

Marital Status (choose all that apply): ___Never married ___Married ____Remarried ___Living together
___Separated ___Divorced ___Widowed ___Partnered

What problems or complaints prompt you to seek help at this time? _____
_____
_____
_____
_____

When did these difficulties begin?_ _____
_____

How have you tried to resolve these difficulties? _____
_____
_____
_____

Have you ever planned or attempted suicide? □ Yes □ No
If "yes" please explain when and what happened:
_____
_____

Have you been in therapy before or received any prior professional assistance for any emotional problems? □ Yes No

What did you get out of prior treatment? _____
_____

What *psychotropic* medications are you *currently* taking? Give dosage and purpose.

What psychotropic medications have been prescribed for you *in the past?*

What physical conditions (e.g., back pain, headaches, sleep apnea, irritable bowel) do you suffer?

_____

Which of the following substances have you used, currently or in the past? Indicate the current frequency of use and the date of last use:

Substance:	**I have never used:**	**Date of last use:**	**No. of drinks or times of use? Indicate per week, per month**
Alcohol	_____	_____	_____
Marijuana	_____	_____	_____
Cocaine	_____	_____	_____
Amphetamines	_____	_____	_____
Hallucinogens (LSD, etc.)	_____	_____	_____
Heroin, etc.	_____	_____	_____
Other:_____	_____	_____	_____

What legal difficulties have you had? _____

_____

Do you feel you have ever been emotionally, physically, or sexually abused or molested? What kid of abuse? By whom? At what age? How frequently? _____

_____

_____

Please provide the names of your family members:

Spouse or partner's name: _____ Age?_____ If deceased, when:_____

Names and ages of your children:

_____

_____

Names and relationship of others in your family or household:

_____

Mother's name: _____ Age? _____If deceased, when: _____

Father's name: _____ Age? _____ If deceased, when: _____

Step-mother's name: _____ Age? _____If deceased, when: _____

Step-father's name: _____ Age? _____ If deceased, when: _____

Others: _____

Which relatives have or had emotional or psychiatric illnesses including alcoholism?

What else do you think I need to know to help you?