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CLIENT INFORMATION QUESTIONNAIRE

Thank you for taking the time to complete this confidential questionnaire. It will help me understand you better as well as help us make the best use of our first appointment together.
Today's Date: _____

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Age: _____

I. CONTACT INFORMATION

Address: _____

Home Phone: _____ May I Call this Number? Y N May I Leave a Message? Y N

Cell Phone: _____ May I Call this Number? Y N May I Leave a Message? Y N

Email: _____May I contact you by email? Y N

What is the best way to reach you? _____

Person Responsible for Bill: _____ Relationship: _____

Address: _____Phone: _____

II. EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship: _____

Address: _____

Cell Phone: _____ Other Phone: _____

III. REFERRAL INFORMATION

How did you hear about me?

❑ Internet Search (Psychology Today) ❑ Internet Search (General)
❑ Professional: _____ ❑ Other Referral: _____

IV. EMPLOYER INFORMATION

Are you employed? ❑ No (Please skip to next section) ❑ Yes Hrs Per week: _____

Employer: _____ Occupation: _____

V. ACADEMIC INFORMATION

Are you a student? ❑ No (Please skip to next section) ❑ Yes

How many classes/credits are you currently taking? _____ What is your GPA? _____

❑ Middle School ❑ High School ❑ College ❑ Graduate School

School: _____ Major/Specialization (if applicable): _____

VI. DEMOGRAPHIC INFORMATION

Please describe yourself as fully as you feel comfortable.

Relationship Status:
❑ Single ❑ Dating ❑ Engaged ❑ Long-Term Relationship/Partnered ❑ Married
❑ Separated ❑ Divorced ❑ Remarried ❑ Widowed

Gender:
❑ Female ❑ Male ❑ Transgender ❑ Other: _____

Sexual Orientation:
❑ Heterosexual ❑ Questioning ❑ Fluid ❑ Bisexual ❑ Gay ❑ Queer

❑Other: _____

Please list your racial/cultural identity:_____

Military Service:
Have you ever been, or are you currently, enlisted in any branch of the US military?
❑ No ❑ Yes & in what capacity did you serve?_____

VII. TREATMENT TEAM INFORMATION

Primary Care Physician: _____Phone: _____ Email:_____

Dietician: _____ Phone: _____ Email:_____

Psychiatrist: _____ Phone: _____ Email:_____

Previous Therapist: _____ Phone: _____ Email:_____

Please list any medical issues or prior hospitalizations: _____

Are you currently taking any prescription medication? ❑ Yes ❑ No If Yes, please list below.

Name of Medication	Date Began Taking	Dose / Times per Day	Condition Being Treated	Name of Prescribing Professional*

**Please make sure that the information for the prescribing doctor is listed above*

VIII. FAMILY INFORMATION

With whom are you currently living?
❑ With Spouse/Family (Please list names/ages):_____
_____
❑ Alone ❑ Roommates ❑ Other: _____
Are you currently involved in any divorce or child custody proceedings? ❑ Yes ❑ No

Please complete the following for people you considered to be part of your family while growing up.

	Current age ("D" if deceased)	Occupation	Known mental health diagnoses:
Mother			
Father			
Step Parent			
Step Parent			
Siblings &/or others:			

Suicidality/Self-Harm:

In the last week, have you had suicidal thoughts (i.e., thoughts of killing yourself)? ❑ Yes ❑ No

If yes, what is the frequency?

❑ Rarely ❑ Sometimes ❑ Frequently ❑ Always

What is the duration?

❑ Seconds ❑ Minutes ❑ Hours ❑ Constant

What is the intensity?

❑ Brief & fleeting ❑ Focused deliberation ❑ Intense rumination & plan

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In the last week, have you had thoughts of self-injury? ❑ Yes ❑ No

If yes, what is the frequency?

❑ Rarely ❑ Sometimes ❑ Frequently ❑ Always

Are you able to commit to safety while attending therapy sessions with me?

❑ Yes ❑ Unsure ❑ No

Substance Use:

In the last two weeks. How many times have you had:

For <u>males</u>: 5+ drinks in a row? For <u>females</u>: 4+ drinks in a row?

❑ None ❑ Once ❑ Twice ❑ 3-5 Times ❑ 6-9 Times ❑ 10+ times

In the last two weeks, how many times have you smoked marijuana?

❑ None ❑ Once ❑ Twice ❑ 3-5 Times ❑ 6-9 Times ❑ 10+ times

In the last two weeks, how many times have you used other recreational drugs?

❑ None ❑ Once ❑ Twice ❑ 3-5 Times ❑ 6-9 Times ❑ 10+ times

Please list the recreational drugs have you used.

_____

_____

_____

IX. PRESENTING CONCERNS

Please check all the following symptoms/issues that you have experienced recently or in the past. Please check both if you have experienced the symptoms recently and in the past:

☐ = Past (one month ago or longer) O = Recently (within the last month)

- ☐ O change in appetite
- ☐ O significant weight gain/loss
- ☐ O restriction of food intake
- ☐ O increased need for exercise
- ☐ O binging on food
- ☐ O purging/vomiting after eating
- ☐ O fertility issues
- ☐ O change in mood
- ☐ O irritability
- ☐ O feelings of worthlessness
- ☐ O changes in sleeping patterns
- ☐ O fatigue
- ☐ O loss of interest in activities
- ☐ O loss or decrease in sexual interest
- ☐ O lost or irregular menstrual cycle
- ☐ O increase of energy
- ☐ O difficulty concentrating
- ☐ O nightmares
- ☐ O problems with attention, motivation, memory, concentration
- ☐ O recurrent or excessive anxiety or worry
- ☐ O panic attacks
- ☐ O career/school issues
- ☐ O grief/loss
- ☐ O identity issues
- ☐ O self-worth/esteem issues
- ☐ O social relationship concerns
- ☐ O familial relationship concerns
- ☐ O parenting concerns
- ☐ O aggression/violence
- ☐ O recurrent thoughts of death
- ☐ O recurrent thoughts of harming self or others
- ☐ O seeing things that others do not
- ☐ O hearing voices that others do not
- ☐ O paranoid thoughts
- ☐ O substance abuse (alcohol or drugs)
- ☐ O odd or unusual experiences
- ☐ O risky behavior/impulsiveness
- ☐ O physical/sexual abuse

Please describe why you are seeking therapy now:

_____

_____

_____

What are your goals or hopes for therapy?

_____

_____

_____

Is there anything that was not asked that you think would be important for me to know?

_____

_____

Thank you for taking the time to fill out this confidential informational questionnaire.

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