NEW CLIENT QUESTIONNAIRE

Welcome! Thank you for taking a few minutes to fill out this form. The information you provide is confidential, and will be helpful for you and your counselor when you meet for the first time. If you have any questions, just ask!

Client Name:	Today's Date:
Date of Birth:	Age:
Address: City: State: Zip:	
Primary Phone Number:	Secondary Phone Number:
Email:	
Ethnicity:	Religious background/involvement:
Education:	Occupation:
Marital Status (check any that apply): Single ___ Dating ___ Committed relationship ___ Engaged ___ Married ___ (how long? _____) Separated ___ (how long? _____) Divorced ___ (how long?_____) Spouse's Name (if applicable) _____ Age _____ Spouse's Occupation _____	
Emergency Contact: Relationship/Phone Number:	

Please describe your current living arrangement:
Where did you grow up?

Have you participated in any therapy before?	Yes No	If yes, when? Reason?

Are you currently seeing a psychiatrist or therapist?	Yes No	If yes, for how long? Reason?

Have you or a family member ever been hospitalized for mental or emotional illness? Yes No
If yes, please explain—dates, where, reason:

_____

Substance abuse / addiction history? No _____ Yes (please explain) _____

_____

Legal History (arrests, prison, DWI, parking tickets?)

_____

Are you on any medications? Yes No If so, please list medications and dosage

_____

Relationship Information

Closest Relationships (please list name, birth date, relationship, and whether they live with you)

Name	Birth Date	Relationship	Living with you?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I would describe my friendships as: Close ___ Somewhat close____ Distant____ Conflicted____
I would describe my relationship with my mother as: Close ___ Somewhat close____ Distant____ Conflicted____
I would describe my relationship with my father as: Close ___ Somewhat close____ Distant____ Conflicted____
How many siblings do you have? _____ How would you describe your relationship with your siblings?

Crisis Information

Are you having any current suicidal thoughts, feelings or actions? Y_____ N_____ If yes, explain:
Any current homicidal or violent thoughts or feelings, or anger-control problems? Y_____ N_____ If yes, explain:

Any issues, hospitalizations, or imprisonments for suicidal or assault behavior? Y_____ N_____ If yes, describe:
Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Y____ N___ If yes, describe:

Treatment Needs

How can we help? Please tell us in your own words what brings you here today:

What are your 2 most important goals for therapy?
1.
2.

There are many common problems that bring individuals, couples and families in for counseling.
Please rate the following problems you are experiencing:
0 = no problem, 1 = mild problem, 2 = moderate problem, 3 = severe problem

Marriage	Divorce/Separation	Alcohol/Drugs	God/Faith
Pre-Marital	Child Custody	Other Addictions	Church/Ministry
Being Single	Disabled	Grief/Loss	Past Hurts
Sexual Issues	Work/Career	Depression	Codependency
Family	School/Learning	Fear/Anxiety	Intimacy
Children	Money/Budgeting	Anger Control	Communication
Parents	Aging/Dependency	Loneliness	Self-esteem
In-laws	Weight Control	Mood Swings	Stress Management

Who referred you to us? _____

THANK YOU for taking the time to fill out this information sheet.
This will be reviewed with you during your first counseling appointment.