

CLIENT QUESTIONNAIRE

Date: _____

Client's name: _____ Birth date: _____ SS#: _____

Name of person completing form: _____ Relationship: _____

Thank you for taking the time to complete this questionnaire. IF THE CLIENT IS A CHILD, PLEASE ANSWER THE QUESTIONS AS THEY RELATE TO THE CHILD. The purpose of this questionnaire is to obtain a picture of you or your child and the current problems. The goal is to develop a treatment plan with you. If you are unsure of how to answer a question, move on to the next question.

Marital status of client		Race/ethnic origin of client (optional)		Sex of client	Custody (if client is a child)
<input type="checkbox"/> Never married	<input type="checkbox"/> Divorced	<input type="checkbox"/> White	<input type="checkbox"/> American Indian	<input type="checkbox"/> Male	<input type="checkbox"/> Mother: _____
<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> African American	<input type="checkbox"/> Asian	<input type="checkbox"/> Female	<input type="checkbox"/> Father: _____
<input type="checkbox"/> Widowed	<input type="checkbox"/> Co-habiting	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Multi-racial/multi-ethnic		<input type="checkbox"/> Joint: _____
			<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____

Present living arrangement:

Alone _____ Friends _____ Foster Care _____
 Family _____ Guardian _____ Other (please describe) _____

Immediate Family	Age	Sex	Relationship	Living in Household		Occupation
				Yes	No	
Client						

Notification in case of emergency:

Name: _____ Address: _____ Home #: _____

Military service: Yes: _____ No: _____ Describe: _____

Employment status:

Full-time (35 or more hrs/week) _____ Retired _____
 Part-time (less than 35 hrs./week) _____ Homemaker _____
 Employed, not working due to illness _____ Full-time student _____
 Unemployed _____ Permanently disabled _____
 Other (please describe): _____

Occupation: _____

Education:

High school/G.E.D.: Yes ___ No ___

Special training: _____

Last grade completed: _____

Highest degree: _____

Currently attending school/grade: _____

Briefly describe why you are seeking help at this time: _____

Describe any exceptional childhood events (e.g., achievement, divorce, illness, adoption, trauma): _____

	Excellent	Good	Fair	Poor
Please rate your experiences (check one):				
Kindergarten				
Grade school				
Middle school				
High school				
College				

How much support do you get from your family, friends, church? (please circle)

Great deal Some Little None

What community resources/self-help groups are you currently utilizing? _____

Describe current social activities (number of friends, play activities, recreational interests and hobbies/leisure activities)? _____

	Yes	No
Did you receive special educational assistance in school?		
Were/are there any problems or concerns with performance or behaviors at school/work?		
Were/are there any legal involvement or problems?		
Are you experiencing financial problems?		
Do you have any problems or concerns related to sexuality or your sexual orientation?		
Has any member of your family, immediate or extended, experienced an emotional problem?		

What do you believe to be your strengths? _____

What do you believe to be your weaknesses? _____

Additional Comments:

Please include any other information you consider might be helpful to better understand the situation: _____

Client name: _____

PSYCHOLOGICAL SYMPTOMS

	Yes	No
Are you currently suicidal? Do you have a suicide plan?		
Suicidal thoughts only?		
Previous suicide attempt at any time?		
Are you currently engaged in aggressive/violent behavior?		
Do you have aggressive/violent thoughts?		
Have you had aggressive/violent behavior or thoughts in the past?		

Current	Past		Current	Past	
		Depressed mood			Excess fear of persons, places, animal, objects, situations
		Daily irritability			Difficulty controlling anger/bad temper
		Lack of interest or pleasure in activities			Psychological abuse
		Increase in appetite			Physical abuse
		Loss of appetite			Sexual abuse
		Difficulty sleeping or poor sleep			Distressing memories that reoccur or intrude
		Decreased need for sleep			Recurrent distressing dreams
		Increased need for sleep			Do you hear or see things that others don't?
		Restlessness or inability to concentrate			Delusions (unreasonable thoughts or beliefs)
		Difficulty making decisions			Compulsive shopping/spending
		Fatigue or loss of energy			Excessive computer/internet usage
		Feelings of worthlessness or guilt			Not able to control impulse to steal
		Feelings of hopelessness			Preoccupation with or frequent gambling
		Recurrent thoughts of death			Compulsive sexual behavior/sexual addiction
		Racing thoughts or ideas			Sense of reliving traumatic events
		Distractibility			Periods of time you cannot remember
		Rapid mood swings			Intense reactions to certain events or anniversaries
		Shortness of breath/dizziness			Avoidance of thoughts or feelings of trauma
		Accelerated heart rate or chest pain			Avoidance of activities or situations of trauma
		Trembling/shaking			Detachment from feelings, people and places

	Sweating/feeling flushed		Binging/compulsive overeating
	Choking		Intentional vomiting
	Nausea		Diuretics or laxative misuse
	Feeling unreal		Excessive dieting
	Numbness or tingling sensation		Compulsive exercising
	Fear of dying or going crazy		

CHEMICAL USE HISTORY

	Never	Rarely	Sometimes	Frequently	Almost always
After drinking or using drugs, I have been unable to remember what happened the day before					
I experience physical discomfort that is relieved by alcohol or drug use					
I am able to drink or use more drugs that I used to without feeling an increased effect					
Does anyone in your family have a problem with alcohol or drugs? If yes, please explain: _____					

Check any substance that you use	Frequency	Amount
Tobacco		
Caffeine		
Alcohol		
Marijuana		
Cocaine		
Other: _____		

HEALTH QUESTIONNAIRE

A. What medical problems or concerns, if any, are you currently having?

B. Are those problems being treated? ___ Yes ___ No By whom? _____

Date of last medical examination: _____ Primary care doctor: _____

What prescription or non-prescription drugs are you currently taking or haven taken in the last six months?

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Allergies: Drug, food, other (please list):

Type of reaction:

	Current	Past		Current	Past
Tuberculosis			High Blood Pressure		
Chronic Bronchitis			Pancreatitis		
Emphysema			Heart Disease		
Thyroid Disorder			Stroke		
Diabetes			Jaundice		
Cancer			Asthma		
Epilepsy (Convulsions)			Anemia		
Liver Disease			Multiple Sclerosis		
Ulcer (stomach) or Duodenum			Fibromyalgia		
Sexually Transmitted Disease			Chronic Fatigue		
Kidney Disorder			Other: _____		

Have you any disabling conditions? ___ Yes ___ No If yes, describe: _____

Family history of serious illness, familial diseases: _____

C. List past hospitalizations (including psychiatric), operations or serious illnesses:

	Year	Hospital or Doctor
1.	_____	_____
2.	_____	_____
3.	_____	_____

Client's signature: _____ Date: _____