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CLIENT QUESTIONNAIRE

Client's Name _____ Date of Birth _____

Spouse's or Parent's Name _____ Date of Birth _____

Address_____ City _____ Zip Code _____

Phone (Home)_____ Work _____ Cell _____

Occupation _____ Gender/Orientation _____

Married _____How Long _____How Many Times _____ Single _____ Widowed _____ Divorced _____

Spouse's Work Phone _____ Health Insurance _____

Referred By_____ Church/Religious Affiliation _____

Members of Household/Family Members	.D.O.B.	Relationship

General Health _____

Name of Physician _____ Medications _____

Spouse or parent's general health _____

Are you or your spouse currently under the care of a psychiatrist, psychologist or counselor? _____

If yes, please specify name and address _____

Have you, your child or your spouse received professional counseling or psychiatrist care in the past? _____

If yes, please indicate name _____

Have you, your child or your spouse ever been hospitalized for an emotional or psychological reason? _____

If yes, please indicate when and where _____

(Client Questionnaire continued)

List Use of Drugs and/or Alchohol (Past and Present)

Drugs How Often First Date of Use Last Date of Use

_____

_____

Alcohol How Often First Date of Use Last Date of Use

_____

_____

Tobacco How Often First Date of Use Last Date of Use

_____

Ever had suicidal thoughts? _____

Any suicidal attempts? _____

Were you sexually molested? _____ By whom? _____

Were you every physically abused?_____ By whom? _____

Were you ever emotionally abused? _____ By whom? _____

Client Signature _____ Date _____

Spouse's/Parent's Signature _____ Date _____

Primary Concern

_____

_____

_____

Counseling Goals

_____

_____

_____

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