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New Client Questionnaire

Date: ________________

Identifying Information:

Name: ____

Address: ____

City: ________________________________ State: __________ Zip: ______________

Date of Birth: ________________________ Current age: ________________

Marital Status: _______________________ Gender: M F

Ethnicity: ___________________________ Religion: ___________________________

Home Phone: _______________________ May we leave a message at this number? Yes No

Work Phone: _______________________ May we leave a message at this number? Yes No

Cell Phone: ________________________ May we leave a message at this number? Yes No

Email: _____________________________ May we contact you via email? Yes No

How do you prefer to be contacted? ____

Insurance Information:

If you enter treatment with me for psychological problems, will you be using your insurance? Yes No

Insurance Carrier: ________________________________ ID#: ____________________

Insurance Holder name: ____________________________ Relation: _______________

Group#: ___________________________ Insurance Holder Date of Birth: _____________

Emergency Contact Information:

Emergency contact person: ____

Phone #: ___________________________ Relationship to you: ________________________________

Presenting Concerns:

What brings you in for services? ____

____

____

What would be your goals?
1. ____
2. ____
3. ____

Who referred you? ____

Medical Information:

Primary Care Physician: ______________________ Phone #: ______________

Address: _____ ____

City: ______________________ State: __________ Zip: ____________

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? **Yes** **No**
(If yes, you will need to sign a "release of information form" in order for me to contact your physician.)

Past Medical History:
Please circle any current or past experiences with the following:

Anemia	Problems with Vision	Congestive Heart Failure
Atrial Fibrillation	Hearing Difficulties	Inflammatory Bowel Syndrome
Asthma	Numbness/Tingling	Weight Gain
HIV/AIDS	Head Injuries	Irritable Bowel Syndrome
Shortness of Breath	Stomach Ulcer	Weight loss
COPD	Nausea/vomiting	Sleep Difficulties
Chronic Pain	Cancer	Jaundice
Chronic Cough	Heartburn/Reflux	Diabetes
Skin Problems	Stroke	Kidney/Bladder Problems
Glaucoma	Chronic Lung disease	Diverticulitis
Sickle Cell	Hernia	Pacemaker
Fatigue	Thyroid Disease	Emphysema
Heart Attack	Colon Polyps	Pancreatitis/Liver Disease
Seizures	Headaches	Sexual Dysfunction
High Blood Pressure	Transfusions	Other: ______________

Past Surgical History:
Please circle any past history with the following:

Appendix

Heart

Knee

Back

Gallbladder

Hysterectomy

Heart Valve Replacement

Stomach

Colon

Hip

Other: ________________________

Other: ________________________

Medications:
Prescribed or over-the-counter (please put additional medications on the back of this page)

Medication	Dosage/Frequency	Condition	Prescribing Physician

Family Medical History:
Have your family members struggled with the following?

Depression	Yes No	Relative: ______________________
Bi-Polar Illness	Yes No	Relative: ______________________
Heart Disease	Yes No	Relative: ______________________
Diabetes	Yes No	Relative: ______________________
Dementia	Yes No	Relative: ______________________
Schizophrenia	Yes No	Relative: ______________________
Anxiety	Yes No	Relative: ______________________
Eating Disorder	Yes No	Relative: ______________________
ADHD	Yes No	Relative: ______________________
Seizures	Yes No	Relative: ______________________
Alcohol/Drug Problem	Yes No	Relative: ______________________
Asthma	Yes No	Relative: ______________________
Blood Pressure	Yes No	Relative: ______________________
Stroke	Yes No	Relative: ______________________
Cancer	Yes No	Relative: ______________________

Legal history
If the answer is "yes" to any items below, please give a brief description

Have you ever been arrested? (including a DUI – Driving Under the Influence) Yes No

____

Have you ever been in prison? Yes No

____

Are you presently being sued, suing anyone or thinking of suing anyone? Yes No

____

Is your reason for coming to see me related to an accident or injury? Yes No

____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment?
Yes No

____

Substance Use:
Have you ever used the following substances?

Substance	Y/N	Current Use?	Amount	How often?	Is this something you would like to change?
Alcohol					
Marijuana					
Cocaine					
Opiates					
Amphetamines					
Hallucinogens					

Do you use tobacco products? Yes No Cigarettes ______ Chew ______

Do you gamble or bet? Yes No How often? _______________
Do you or family, friends or employers have concerns about your gambling? Yes No

How many hours a day do you spend online? ______ Do you feel your technology use is balanced and healthy, or could it be improved? ____

Previous Behavioral Health Services: (such as with a Psychologist, Social Worker, Psychiatrist, Counselor or Psychological Testing)

With Whom	When	Type of Treatment	Were you hospitalized? Where?

Was anything in your previous treatment(s) particularly helpful? Not helpful?

Problems:

How often have you experienced the following?

Problem	**Never**	**Sometimes**	**Often**	**Always**
Excessive Sadness				
Nervousness				
Racing Thoughts				
Low Energy				
High Energy				
Suicidal Thoughts Have you ever attempted suicide? Yes No				
Thoughts of Harming Others				
Sense of Hopelessness				
Panic				
Angry Outbursts				
Increased Appetite				
Decreased Appetite				
Sleep Difficulties				
Problems related to eating				
Hallucinations				
Trouble Concentrating				
Irritability				
High anxiety				
Worry				
Self Abuse (i.e., cutting/burning)				

Employment/Education:

Current Occupation: ______________________________

Years in field: __________

Current Employer: ______________________________

Relevant Past employment: ______________________________

Highest level of education attained: ______________________________

Are you currently enrolled in school? Yes No

If yes, what type of education are you receiving? ______________________________

Current Living Situation:
Who is currently living with you?

Person	Age	Relationship

Your signature: ______________________ Today's date: __________

My signature: ______________________ Date reviewed with you: __________

Thank you for completing the questionnaire.
Please bring this completed form to our first session.