Michael Feeley, PhD
Licensed Psychologist
PO Box 244 Haverford, PA 19041-0244
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New Client Questionnaire

Today's Date:

Identifying Information:

Name:
Address:
City: State: PA Zip:
Date of Birth: Current age:
Marital Status:
Gender: ☐ Male ☐ Female ☐ Other:
Ethnicity: Religion:
Home Phone: May we leave a message here? ☐ Yes ☐ No
Work Phone: May we leave a message here? ☐ Yes ☐ No
Cell Phone: May we leave a message here? ☐ 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 :
Address:
Phone #:
Relationship to you:

Presenting Concerns:

What brings you in for services?

What would be your goals?

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How did you find me? 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 check 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 check any past history with the following:

☐ Appendix	☐ Heart	☐ Knee
☐ Back	☐ Gallbladder	☐ Hysterectomy
☐ Heart Valve Replacement	☐ Stomach	☐ Colon
☐ Hip	☐ Other:	☐ Other:

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Medications:

Prescribed or over-the-counter

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:	

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Legal history

If 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	☐ Yes ☐ No.	☐ Yes ☐ No.			☐ Yes ☐ No.
Marijuana	☐ Yes ☐ No.	☐ Yes ☐ No.			☐ Yes ☐ No.
Cocaine	☐ Yes ☐ No.	☐ Yes ☐ No.			☐ Yes ☐ No.
Opiates	☐ Yes ☐ No.	☐ Yes ☐ No.			☐ Yes ☐ No.
Amphetamines	☐ Yes ☐ No.	☐ Yes ☐ No.			☐ Yes ☐ No.
Hallucinogens	☐ Yes ☐ No.	☐ Yes ☐ No.			☐ Yes ☐ No.

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?

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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?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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

Current 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	☐	☐	☐	☐

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Problem	Never	Sometimes	Often	Always
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.