Initial Client Questionnaire

Please complete this document in its entirety.

Client Name: Date of Birth:

Address: Phone #:

How did you hear about us?

What is the reason for your appointment today?

What has been your experience in psychotherapy / counseling so far?

Have you ever been diagnoses with a mental illness? 󠄀󠄀 Yes 󠄀󠄀 No

Are you presently in psychotherapy / counseling with anyone? 󠄀󠄀 Yes 󠄀󠄀 No

If Yes, who?

Any present psychotherapy testing? 󠄀󠄀 Yes 󠄀󠄀 No - If yes do you have reports? 󠄀󠄀 Yes 󠄀󠄀 No

Have you been hospitalized for psychiatric problems? 󠄀󠄀 Yes 󠄀󠄀 No. If yes, how many times?

When was the last time?

What is your opinion of psychiatric medications?

How many psychiatrists have you seen previously for medication management?

What has been your experience with medications so far?

Have you ever attempted suicide and / or currently planning to attempt suicide? 󠄀󠄀 Yes 󠄀󠄀 No

Do you have suicidal thoughts? 󠄀󠄀 Yes 󠄀󠄀 No

Have you ever physically harmed yourself and / or are currently harming yourself? 󠄀󠄀 Yes 󠄀󠄀 No

Do you have thoughts of seriously harming yourself or others now? 󠄀󠄀 Yes 󠄀󠄀 No

Your education level:

***Symptoms:***

* Have you been down, depressed, or hopeless in the past month? 󠄀󠄀 Yes 󠄀󠄀 No
* Are you bothered by little interest of pleasure in doing things? 󠄀󠄀 Yes 󠄀󠄀 No
* Has your appetite changed (eating more or less)? 󠄀󠄀 Yes 󠄀󠄀 No
* Has your sleep been disturbed (insomnia or over-sleeping)? 󠄀󠄀 Yes 󠄀󠄀 No
* Do you feel worthless or guilty? 󠄀󠄀 Yes 󠄀󠄀 No
* Do you have sudden or unexpected bouts of anxiety or nervousness? 󠄀󠄀 Yes 󠄀󠄀 No
* Do you often feel tense, worried, or stressed? 󠄀󠄀 Yes 󠄀󠄀 No
* Do you have acute onset of symptoms such as palpitations, shortness of breath, or trembling?󠄀 󠄀󠄀 Yes 󠄀󠄀 No
* Do you worry about a lot of different things? 󠄀󠄀 Yes 󠄀󠄀 No
* Do you avoid places or situations because of anxiety or worry? 󠄀󠄀 Yes 󠄀󠄀 No
* Do you have recurrent, persistent or unwanted thoughts or do repetitive behaviors? 󠄀󠄀 Yes 󠄀󠄀 No
* Have you been through any significantly stressful periods in the past six months? 󠄀󠄀 Yes 󠄀󠄀 No
* In your lifetime, have you faced any potentially life-threatening events such as natural disaster, serious accident, physical / emotional / psychological / sexual assault / abuse, or military combat? 󠄀󠄀 Yes 󠄀󠄀 No

**If “YES” to having experienced any of the above listed stressors:**

* Have you now become easily startled? 󠄀󠄀 Yes 󠄀󠄀 No
* Angry or irritable? 󠄀󠄀 Yes 󠄀󠄀 No
* Emotionally numb or detached from your feelings? 󠄀󠄀 Yes 󠄀󠄀 No
* Prone to physical reactions when reminded of the event? 󠄀󠄀 Yes 󠄀󠄀 No

Do you use prescription medications, street drugs, and / or alcoholic beverages to relax, calm your nerves, or get high? 󠄀󠄀 Yes 󠄀󠄀 No

**If “YES”:**

* Have you made an effort to cut down on your drinking and / or drug use? 󠄀󠄀 Yes 󠄀󠄀 No
* Have you been annoyed by people who criticize your drinking and / or drug use? 󠄀󠄀 Yes 󠄀󠄀 No
* Do you ever feel guilty about your drinking and / or drug use? 󠄀󠄀 Yes 󠄀󠄀 No
* Do you ever drink and / or use drugs to steady your nerves, get rid of a hangover, or to relieve withdrawal symptoms? 󠄀󠄀 Yes 󠄀󠄀 No

Your occupation / work:

Did you have a happy childhood? 󠄀󠄀 Yes 󠄀󠄀 No

Were you raised by your parents? 󠄀󠄀 Yes 󠄀󠄀 No

How were your relationships with your parents growing up?

How is your relationship with your parents now?

Were you abused or molested as a child? 󠄀󠄀 Yes 󠄀󠄀 No

How many times have you been married?

Who do you presently live with?

How many children do you have?

What are the major problems present in your current household?

Who is supportive of you at this time?

Are you facing any legal difficulties at the time 󠄀󠄀 Yes 󠄀󠄀 No

How much difficulty are you having presently in functioning at your work / home / school life?

What religious and spiritual values are important to you?

What are some of your strengths and abilities?

What are some of your needs?

Do you have any specific preferences for your care (if so, please describe)?

**Substance Use History**:

|  |  |  |  |
| --- | --- | --- | --- |
| Substance | Age at First Use | Date / Age at Last Use | Duration & Frequency of Use |
| Alcohol |  |  |  |
| Marijuana |  |  |  |
| Methamphetamines |  |  |  |
| Amphetamines |  |  |  |
| Cocaine |  |  |  |
| Benzodiazepines |  |  |  |
| Barbiturates |  |  |  |
| Hallucinogens |  |  |  |
| Opiates (Prescription) |  |  |  |
| Methadone |  |  |  |
| Heroin |  |  |  |
| PCP (Angel Dust) |  |  |  |
| Inhalants |  |  |  |
| Prescription Drugs |  |  |  |
| Other illicit Substances |  |  |  |
| Caffeine |  |  |  |
| Tobacco (smoking / chewing |  |  |  |

Have you ever had treatment for substance abuse? 󠄀󠄀 Yes 󠄀󠄀 No

Do you have any medication allergies? 󠄀󠄀 Yes 󠄀󠄀 No

Environmental / Food allergies? 󠄀󠄀 Yes 󠄀󠄀 No

If “YES”, please describe:

**Family History of Psychiatric Illness**:

|  |  |
| --- | --- |
| **Problem / Illness** | **In Which Family Member** |
| Nervous Breakdown |  |
| Depression |  |
| Bipolar Disorder |  |
| Anxiety / Panic |  |
| Drug Abuse |  |
| Alcohol Abuse |  |
| Suicide with a Gun |  |
| Suicide (other method) |  |
| Violent Crime |  |
| Survivor of Abuse (physical, emotional, psychological, etc.) |  |
| Abuser or Molester |  |

**Circle All Problems Present Now or in the Past:**

|  |  |  |  |
| --- | --- | --- | --- |
| Allergies | Asthma | Chronic Cough / Bronchitis | Snoring |
| Chest Pain | Heart Problems | Palpitations | Mitral Valve Prolapse |
| Swelling of Feet | High Blood Pressure | Thrombosis | On Blood Thinners |
| Problem with Urination | Miscarriage(s) | Problems of a Sexual Nature | Sexually Transmitted Disease |
| Abortions | HIV / AIDS | Weight Gain | Weight Loss |
| Diarrhea | Constipation | Liver Problems | Heartburn / Indigestion |
| Stroke | Headaches | Ringing in Ears | Hearing Aids |
| Visions Problem(s) | Thyroid Problems | Infection(s) | TB |
| Genetic Problems | Diabetes Mellitus | High sensitivity to medications | Seizures |
| Nausea and Vomiting | Arthritis / Muscle Pain | Numbness or Tingling | Other Problems: |

**Family History of Physical Illness**:

|  |  |
| --- | --- |
| **Problem / Illness** | **In Which Family Member** |
| Diabetes |  |
| Heart Disease |  |
| Sudden-Death |  |
| Other Major Illness(es) |  |

Who is your Primary Care Physician?

Other Doctors seen regularly:

Current non-psychiatric medications:

Is there any other information you would like your therapist to be aware of?