Initial Client Questionnaire

Client name: _____ Date of Birth: _____

How did you hear about us? _____

What is the reason for your appointment today?

How many psychotherapists/counselors have you seen in past for this problem and related problems?

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

Have you even been diagnosed with a mental illness? ☐ Yes / ☐ No

Are you presently in psychotherapy/ counseling with anyone? ☐ Yes / ☐ No
If Yes, Who?

Any previous psychological testing? _____ Do you have reports? ____

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 medication so for? _____

Have you attempted suicide in the past? ☐ Yes / ☐ No

Do you physically hurt yourself? ☐ Yes / ☐ No

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

Your education level: _____

Symptoms:	*YES*	*NO*
Have you been down, depressed, or hopeless in the past month?		
Are you bothered by little interest or pleasure in doing things?		
Has your appetite changed (eating more or less)?		
Has your sleep been disturbed (insomnia or over-sleeping)?		
Do you feel worthless or guilty?		
Do you have sudden or unexpected bouts of anxiety or nervousness?		
Do you often feel tense, worried, or stressed?		
Do you have acute onset of symptoms such as palpitations, shortness of breath, or trembling?		
Do you worry about a lot of different things?		
Do you avoid placed or situations because of anxiety or worry?		
Do you have recurrent, persistent or unwanted thoughts or do repetitive behaviors?		
Have you been through any significantly stressful periods on the past 6 months?		
In your lifetime, have you faced any potentially life-threatening events such as natural disaster, serious accident, physical or sexual assault/abuse, military combat or child abuse?		
Since you experienced any of these stressors, have you been easily startled?		
Angry or irritable?		
Emotionally numb or detached from your feelings?		
Prone to physical reactions when reminded of the event?		
Do you use prescription medicines or street drugs to relax, calm your nerves, or get high?		
Have you made an effort to cut down on your drinking or drug use?		
Have you been annoyed by people who criticize your drinking or drug use?		
Do you ever feel guilty about your drinking or drug use?		
Do you ever drink or use drugs to steady your nerves, get rid of a hangover, or relieve withdrawal symptoms?		

Your occupation / work: _____

Did you have a happy childhood? ☐ Yes / ☐ No

Where you raised by your parents? ☐ Yes / ☐ No

How was your relationship 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 in your present household?

Who is supportive of you at this time?

Are you facing any legal difficulties at this time? ☐ Yes / ☐ No

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

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 yes, 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; If yes, describe:

Environmental/food allergies? ☐ Yes / ☐ No; If yes, 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)	
Violent crime	
Survivor of abuse	
Abuser or Molester	

Circle all problems present now or in 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	Miscarriages	Sexual problems	Sexually Transmitted Diseases
Abortions	HIV	Weight gain	Weight loss
Diarrhea	Constipation	Liver problems	Heartburn/indigestion
Stroke	Headaches	Ringing in ears	Hearing aids
Vision problems	Thyroid problems	Infections	TB
Genetic Problems	Diabetes mellitus	High sensitivity to medications	Seizures
Nausea and vomiting	Arthritis/muscle pains	Numbness or tingling	Other problems:

Family history of physical illness:

Problem/Illness	In Which Family Member
Diabetes	
Heart disease	
Sudden-death	
Other major illness	

Who is your Primary Care Physician? _____

Other doctors seemed regularly:

Current non-psychiatric medications:

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