

Psychotherapy Client Questionnaire

Name: _____ Date: _____

REFERRED BY:

Name: _____ Phone #: _____

Address: _____

May I inform this person that you have consulted with me? _____

Your Signature

CONFIDENTIALITY STATEMENT:

Case records are strictly confidential. No outsider, not even your closest relative or family doctor, is permitted to see your case record without your written permission or a court order.

1. GENERAL

A. Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Fax: _____ E-Mail: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

B. What is your present living situation? _____

C. Names and ages of children

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

D. Give a short history of your closest interpersonal relationships:

Education: _____

Occupation: _____

Currently working: _____

What is your present job situation? _____

2. PROBLEM AREA

A. State in your own words the nature and history of your chief complaint:

B. Present interests, hobbies, activities: _____

C. How is most of your free time occupied? _____

D. What are your life goals? _____

E. What are your five greatest fears?

1. _____

2. _____

3. _____

4. _____

5. _____

3. FAMILY HISTORY

A. Father's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

Your age at time of father's death: _____

C. Brothers/Sisters (Names, sex, age, and something about each):
[Are there significant others from your growing up years?]

D. Who are the most important people in your life? Describe.

Previous Medical, Psychiatric, and Psychotherapy Contacts

E. Have you ever been in psychotherapy before? _____

If yes, when? _____

May I contact your previous therapist(s)? _____

Therapist: _____

Address: _____

Phone: _____

Therapist: _____

Address: _____

Phone: _____

F. Have you ever been hospitalized for an emotional problem?

If yes, when, where, and how long? _____

If yes, when, where, and how long? _____

G. Have you ever made a suicide attempt? If yes, describe it, when, and the circumstances leading up to the attempt.

H. Have any close relatives been treated for psychiatric problems?

If yes, please specify: _____

I. Has any relative of yours committed suicide?

If yes, please specify: _____

J. Give details of all forms of abuse you were subject to in childhood (neglect, verbal violence, sexual).

5. MEDICAL HISTORY

A. Have you had any of these childhood illnesses?

	NO	YES	DON'T KNOW
Measles	_____	_____	_____
Mumps	_____	_____	_____
Whooping cough	_____	_____	_____
Chicken pox	_____	_____	_____
Rheumatic fever	_____	_____	_____
Rubella (German measles)	_____	_____	_____

Please list all medical hospitalizations and operations. Give diagnoses and dates:

(continue on reverse)

B. Have you ever suffered from any of the following illnesses?

	NO	YES	DATE OF ONSET
Cancer	_____	_____	_____
TB	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid trouble	_____	_____	_____
Kidney trouble	_____	_____	_____
High blood pressure	_____	_____	_____
Eye trouble	_____	_____	_____
Heart trouble	_____	_____	_____
Neurological disease	_____	_____	_____
Ulcers	_____	_____	_____
Head injury	_____	_____	_____
D.T.'s	_____	_____	_____
Allergies	_____	_____	_____

List all allergies: _____

Any other serious illnesses? _____

C. Family History

Have any of your blood relatives suffered from any of the illnesses listed above? If yes, please specify ailment and relative:

Any other serious illness? _____

D. Drug/Medication History

Because many drugs (legal and illegal) have psychological effects, it is important for me to know what drugs you are *currently* taking and/or *have taken in the past*. This information will remain strictly confidential, but it is very important for me to know before you begin therapy so that an accurate assessment of your problem and situation can be made. Please list *all* legally prescribed and illegal drugs ever used (past or present) and describe how often you use them and what effects you seek:

Have any of these drugs been prescribed by a physician?

Yes ___ No ___ If so, which drugs and for what reason?

E. Nutrition

Is your diet unusual in any way? Yes ___ No ___

If so, how? _____

F. Symptoms

Check any of the following symptoms that apply to you at this time. Also indicate when any of these symptoms have applied to you in the past.

- | | |
|------------------------|--------------------------------------|
| Hair falling out _____ | Fainting spells _____ |
| Weight gain _____ | Difficulty sleeping _____ |
| Fatigue _____ | Drinking too much fluid _____ |
| Constipation _____ | Blurred vision _____ |
| Dry skin _____ | Deafness _____ |
| Weakness _____ | ringing in ears _____ |
| Weight loss _____ | Chest pain _____ |
| Tremor _____ | Shortness of breath _____ |
| Big appetite _____ | Tingling of hands or feet _____ |
| Fast heart beat _____ | Ankle swelling _____ |
| Diarrhea _____ | Indigestion _____ |
| Poor appetite _____ | Nausea or vomiting _____ |
| Headaches _____ | Urinary difficulties _____ |
| Dizziness _____ | Problems with sexual
organs _____ |

G. Menstrual History, Issues, or Problems: _____

H. Smoking and Drinking

Do you smoke (anything)? _____ What? _____

How much? _____ Frequency? _____

Do you drink alcohol? _____ If yes, how much? _____

What happens to you when you smoke or drink, that is, what does it do for you?

Describe any physical symptoms at all that you have when you smoke or drink.

I. What kind, and how much physical exercise do you get?

J. Describe the spiritual/religious aspects of your life:

K. Have you ever been hypnotized? If so, for what and what were the results?

L. Have you ever been on worker's comp or disability? For what, how long, results?

M. In case of emergency, please notify one of the following three people: May I have your permission to inform one or all of these people if you are ever in danger?

Yes _____ No _____

1.	_____	_____	_____	_____
	Name	Daytime Phone	Evening Phone	Address
2.	_____	_____	_____	_____
	Name	Daytime Phone	Evening Phone	Address
3.	_____	_____	_____	_____
	Name	Daytime Phone	Evening Phone	Address

This questionnaire supplements previous informed consents.

Your Signature

Date

Therapist's Signature

Date

For Therapist Use Only!

Diagnostic Impressions:

Date

Treatment Plan:

Date

Referrals:

_____ Date _____

_____ Date _____