CONSUMER INFORMATION QUESTIONNAIRE

Welcome to my practice. Thank you for taking the time to give me some information about you or your child/adolescent who needs counseling. If you have questions, please ask me when I meet with you.

Date: ______________________

Consumer Data:
First Name: _________________________ M.I. _______ Last Name: ______________________________

Age: __________ Date of birth: ______/______/_______ Social Security #: _____-_____-_______

What sex were you assigned at birth? Male Female Intersex Decline to answer
What pronouns do you prefer? He/Him She/Her They/Them Other: _________________________

Address:____ City: ________________ State: _____ Zip:_____

Home: (_____)_______________ Cell: (_____)_______________ Work: (_____)_______________
May we leave messages on an answering machine or voicemail regarding appointments? ☐ Yes ☐ No

Send appointment reminders to:
Mobile: (_____)_______________ Mobile Carrier: __________ &/or Email: _______________________

Send invoices &/or receipts for payment to: Email: ____

Employment: Full-time (35+) Part-time Unemployed Homemaker Student Retired Disabled

Occupation: __________________________________ Employer: _______________________________

Address: ____________________________ City: _________________ State: ______ Zip: ___________

Highest level (grade) of education completed: ____________________ Current Grade: ______________

Name of School: ____ City: _______________________

In consumer is a minor, are parents divorced? Yes No "Joint Custody"? Yes No
If parent's are divorced, who has sole custody? Mother Father Name: _________________________

Marital Status: Single Married Divorced Separated Widowed

Spouse's Name: ____ Date of Present Marriage: ___________

Age: __________ Date of birth: ______/______/_______ Social Security #: _____-_____-_______

Employment: Full-time Part-time Unemployed Not in Labor Force Highest level of education: __

Occupation: __________________________________ Employer: _______________________________

Address: ____________________________ City: _________________ State: ______ Zip: ___________

Spouse's Work phone: (_____)_______________ Cell phone: (_____)________________________

Dates of Previous Marriages: ________ to ________, ________ to ________, ________ to ________

Children:

Name:	Age	Gender	Living at home?
____________________	_______	F / M	Yes / No
____________________	_______	F / M	Yes / No
____________________	_______	F / M	Yes / No
____________________	_______	F / M	Yes / No
Mother Name:________________	_______	F / M	Yes / No
Father Name:________________	_______	F / M	Yes / No
Sibling Name:________________	_______	F / M	Yes / No
Sibling Name:________________	_______	F / M	Yes / No
Sibling Name:________________	_______	F / M	Yes / No

Medical:

Are you in good health? ☐ Yes ☐ No Explain: ______________________________

List any on-going health problem for which consumer is currently or recently receiving treatment:

______________________________ Currently under medical Treatment?
Condition Treating physician ☐ Yes ☐ No

______________________________ Currently under medical Treatment?
Condition Treating physician ☐ Yes ☐ No

______________________________ Currently under medical Treatment?
Condition Treating physician ☐ Yes ☐ No

List all current medications:

Medication	Dosage	Frequency	Reason	Physician

Permission to Speak to Others in an Emergency:
List person(s) with whom we can contact and speak to in case of an emergency:

1.____

Contact Person | Relationship to Consumer | Phone Number

2.____

Contact Person | Relationship to Consumer | Phone Number

Responsible Party to Bill:
Check whichever applies: ☐ Self-Pay ☐ File Insurance

First Name: _________________________ Last Name: ____

Address: __________________________________ City: __________________ State: ____ Zip:______

Phones – Home: (___) ________________ Cell: (___) ________________ Work: (___) ______________

Relationship to consumer: ☐Self ☐Spouse ☐Parent ☐Other (Explain): _________________

Insurance:

PRIMARY INSURANCE:

____
Name of Insurance

____
Insured's Name (Last, first, MI)

_______/_________/__________________________
Insured's Date of Birth

____
Insured's ID Number

____
Insured's Group Number

____
Insured's Employer

(_______)____________________________________
Insured's Work Telephone Number

SECONDARY INSURANCE:

____
Name of Insurance

____
Insured's Name (Last, first, MI)

_______/_________/_______________________
Insured's Date of Birth

____
Insured's ID Number

____
Insured's Group Number

____
Insured's Employer

(_______)__________________________________
Insured's Work Telephone Number

Referral:
Who referred you to this office? ______________________________

☐ Physician ☐ Friend ☐ School ☐ Other (Explain): ______________

Reason for Seeking Services:
Briefly describe your reasons for seeking help: ______________________________

____

____

When did these problems first begin? ______________________________

Have you ever had previous mental health & substance abuse treatment? ☐ Yes ☐ No

Date(s)	Counselor / Hospital	Date(s)	Counselor / Hospital

Symptom Concerns:
Please circle any of the following problems which pertain to you in the past 30 days.

Nervousness	Depressed	Fear	Shyness	Suicidal thoughts
Homicidal thoughts	Sexual problems	Separation	Divorce	Finances
Overwhelmed	Stressed	Drug Use	Alcohol Use	Friends
Anger	Self-Control	Unhappiness	Sleep	Work
Relaxation	Headaches	Tiredness	Natural Disasters	Memory
Ambition	Legal Matters	Learning Disability	Boyfriend	Girlfriend
School	Insomnia	Making Decisions	Energy	Inferiority Feelings
Concentration	Loneliness	Career Choices	Health Problems	Education
Nightmares	Marriage	Temper	Changes in Appetite	Stomach Troubles
Parenting	Communication	Disturbing Thoughts	Bowel Troubles	Tension
Anxiety	Moodiness	Unusual Experiences	Confusions	Excessive Worry
Abuse	Death	Family	Irritability	Boredom
Hopelessness	Loss of Interest	Gambling	Self-Esteem	Problem Solving

I give permission for this office to speak to the person(s) listed on page 3 of this questionnaire in the event of an emergency.

Consumer Signature	Date	Parent/Guardian Signature *(if consumer is a minor)*	Date