Client Questionnaire

Please fill in the following questionnaire and return via email. All questions need to be completed and returned before the first session can commence.

Personal Details

Full Name and Preferred Pronoun	
Address	
Date of Birth	
Email Address	
Telephone Number	
GP Name and Address	
Next of Kin Name and Telephone Number	

Presenting Issue

What is your reason for seeking therapy at present?	
Have you consulted your doctor about this issue?	

Medical History

Please answer yes or no and provide further details where requested

Are you taking anti-depressants?	
Are you taking tranquillisers?	
Are you taking sleeping pills?	
Are you prescribed any other psychoactive medication? (If 'yes' please include what medication and for what symptoms)	
Have you ever received any other form of psychiatric or psychological treatment? (If 'yes' please include what treatment and for what symptoms)	
Have you ever attempted suicide?	

Do you currently have or have ever had have any mental health diagnoses? If 'yes' please include what diagnoses.	
Do you suffer from or have you ever suffered from epilepsy?	
Do you suffer from asthma?	
Do you suffer from diabetes?	
Do you have any other medical diagnoses? If 'yes' please include what diagnoses	

Psychological Challenges

If you have a problem with any of the following, please tick:

Trauma		Eating Issues	
Abuse		Stress	
Addictions		Insomnia	
Panic Attacks		Exhaustion	
OCD		Physical Illness / Unexplained medical symptoms	
Phobias		Physical Pain	
Self-Harm		Concentration Issues	
Suicidal Thoughts / Feelings		Sexual Issues	
Gender Issues		Clinical Depression	
Low Confidence		Low Mood	
Problems with Anger		Unwanted Habits	
Grief		Relationship Issues	
Emotional Numbing		Spiritual Issues	

Final Questions

Do you have any other problem not listed above? If 'yes' please give details	
Is there anything else you would like to add?	

Client Name: .....

Client Signature: .....

Date .....