NIA COUNSELING & FAMILY SERVICES, PLLC

WHERE CULTURE, MEETS CARE

+19193075320
Niafamilylife@gmail.com
Www.NiaFamilyLife.com

NEW CLIENT INITIAL QUESTIONNAIRE

Please complete this before your first session. Completing this questionnaire will help us be;er understand your needs and develop a comprehensive plan together. Thank you for taking the time to fill out this form.

Name_____ Age: _____ DOB: _____ Address_____Referring provider _____ Referrer's phone _____ Primary Care Physician_____ PCP's Phone _____ Current Therapist _____ Therapist's Phone_____ Current Psychiatrist/Psychopharmacologist _____ Prescriber's Phone_____

What are the reason(s) you are seeking help?

_____

_____

_____

What are your treatment goals?

_____

_____

_____

Have you ever been in counseling or therapy before? If so, explain (when, why, and what type of treatment).

_____

_____

_____

Current Living Situation

Please list all immediate family members as well as other people currently living in your home. Put a star (*) next to the people that currently live with you.

Name:	Age:	Relationship	Occupation/ Grade:

Social History

Where were you born? _____ Where did you grow up? _____

How many siblings do you have? None _____Brothers _____Sisters_____

Did you suffer from any major illnesses/injuries while you were growing up? ☐ Yes ☐ No

If so, please describe.

_____

_____

_____

Please describe your childhood.

_____

_____

_____

_____

_____

Highest level of education: _____ Degree: _____ Field of study: _____

What is your current employment status?

☐ Employed (Where and what do you do? How long have you worked at your current job?)

_____

_____

☐ Retired from and when

_____

☐ Unemployed (reason)

_____

What types of jobs have you had in the past?

_____

_____

_____

Are you currently involved in a romantic relationship? ☐ Yes ☐ No

Relationship Status: ☐ Single ☐ Dating ☐ Life Partner ☐ Married ☐ Divorced ☐ Widowed

Spouse/partner's name: _____ How long have you been together?

How would you describe your relationship?

_____

_____

_____

Do you feel like you have a strong support system (family, friends)? ☐ Yes ☐ No
Please describe your interests and hobbies.

_____
_____
_____

Please describe your spiritual orientation and how important religion/spiritual beliefs are in your life?

_____
_____
_____

Have you had any legal issues (e.g., arrests, charges, time in jail)? ☐ Yes ☐ No. If so, please describe.

_____
_____

Medical History

Do you have any physical symptoms that concern you? ☐ Yes ☐ No
If Yes, please list:

Do you have any concerns regarding your health: ☐ Yes☐ No
If Yes, please list:

Are you currently being treated for any medical conditions? ☐ Yes ☐ No If Yes, please list:

Are there any specialists involved in your care? ☐ Yes ☐ No
If Yes, please list

Please list all current medications you are taking, including any vitamins or herbal supplements:

Medication name	Reason for taking	Dose	Is it effective?	Any side effects?

Please list all allergies or any adverse drug reactions:

_____

_____

_____

Psychiatric history

Have you been ever diagnosed with a mental health condition (e.g. Depression, bipolar, schizophrenia, ADHD)? If so, please list all diagnoses.

_____

_____

_____

Have you ever experienced verbal, physical, emotional, or sexual abuse? Or been the victim of a violent crime? If so, please describe.

_____

_____

_____

Have you ever been hospitalized for a psychiatric reason? ☐ Yes ☐ No If YES, please list and describe.

Dates	Location and reason	Type of treatment during stay

Have you ever taken any medications for emotional, behavioral, or psychological reasons?
☐Yes ☐ No
If yes, please list all medications, including ones you no longer take.

Dates	Medication name	Dose	Reason for taking	Was it effective?	Any side effects?

Substance Use history

Please describe your experience with the following substances

Use	Substance	Age when started	Frequency of use (per day/wk/mo)	Amount of use	Have you ever received treatment for misuse? If so, when?
☐ Yes ☐ No	Caffeine				
☐ Yes ☐ No	Tobacco				
☐ Yes ☐ No	Alcohol				
☐ Yes ☐ No	Cannabis /Marijuana				
☐ Yes ☐ No	Amphetmines / Stimulants				
☐ Yes ☐ No	Cocaine				
☐ Yes ☐ No	Hallucinogens				
☐ Yes ☐ No	Opiates/ heroin				
☐ Yes ☐ No	Inhalants				
☐ Yes ☐ No	Sedative /hypnotics				
☐ Yes ☐ No	Prescription medication (for recreational reasons)				

Family Mental Health History

Is there any known history of the following conditions in your family?

Condition	Mother	Father	Sibling	Children	Other member
Alcohol or drug abuse					
Anxiety (e.g., Panic, Worry, Phobia, OCD)					
Schizophrenia					
Depression					
Bipolar Disorder					
Eating Disorder (Anorexia or Bulimia)					
Prior Inpatient Psychiatric Hospitalizations					
Prior Completed or Attempted Suicide					

Safety

Do you currently have thoughts of hurting yourself or ending your life? ☐ Yes ☐ No If so, please describe.

_____

_____

_____

Have you ever attempted suicide? ☐ Yes ☐ No If so, please explain.

_____

_____

_____

Do you engage in self-harm behaviors like cutting, burning, picking, or other forms of self-injury?
☐ Yes ☐ No If so, please describe.

_____

_____

_____

CHECK ITEMS THAT APPLY TO WHAT YOU HAVE BEEN EXPERIENCING RECENTLY: __ headaches __ nightmares __ can't stay asleep __ dizziness __ sexual problems __ ready to explode __ stomach problems __ financial problems __ unable to work/study __ bowel problems __ depressed/sad __ can't get interested __ feel tense __ panicky feelings __ can't have a good time __ irritable __ feel hopeless __ trouble concentrating __ unusual thoughts __ always worried __ can't make/keep friends __ strange experiences __ unable to relax __ fear loss of self-control __ weight change __ feel worthless __ feel apart from family __ always tired __ hard to make decisions __ fear things I shouldn't __ can't go to sleep __ thoughts of suicide __ conflict within family __ racing thoughts __ enjoy high-risk situations __ don't need a lot of sleep __ restrict food intake __ binge/purge __ thoughts of self-harm __ identity concerns __ test anxiety __ acts of self-harm __ work conflict __ career/future confusion __ Motivation challenges

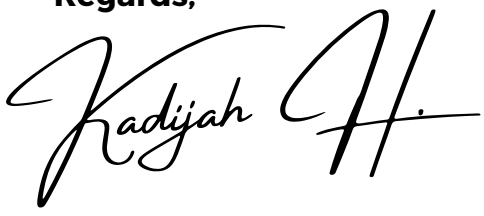
OTHER current feelings or symptoms not mentioned above:

_____

_____

_____

Regards,



Kadijah Harris, LCSW

Outpatient Therapist