

## Confidential Client Questionnaire

		Т			Today's Date	Today's Date//_	
Demographics							
Name					Date of Birth/	/	
Address							
Si	treet			city	state	zip	
Primary Phone (	)		□ Cell	□ Home □ Work	OK to leave a message?	Y N	
Secondary Phone (	)		□ Cell	□ Home □ Work	OK to leave a message?	Y N	
Email <i>(nlease nrint cle</i>	arly)						
inan (picase print ele	urry)						
Relationships							
Relationship status <i>(cl</i>	heck all the	at apply):					
□ single □ d	ating □ o	ngaged - committe	od rolatio	nchin	□ separated □ divorced		
_	_			-	-		
spouse/partn	er name_		age	occupation	n		
Please list any childre	n either yo	u or your spouse/pa	rtner have	e:			
		Age Relationship to you		you Live wi	th you?		
					□ Y	□N	
						$\square$ N	
					□ Y	$\square$ N	
					□ Y	$\square$ N	
Please describe your r	elationshi <sub>l</sub>	ps with the following	g people ir	n your life:			
Partner:	□ close	$\hfill\Box$ somewhat close	□ distan	t □ conflicted			
Children:	□ close	$\hfill\Box$ somewhat close	□ distan	t □ conflicted			
Mother:	□ close	$\hfill\Box$ somewhat close	□ distan	t □ conflicted			
Father:	□ close	$\ \square$ somewhat close	□ distan	t □ conflicted			
Siblings:	□ close	$\ \square$ somewhat close	□ distan	t □ conflicted			
Friends:	□ close	□ somewhat close	□ distan	t 🗆 conflicted			
Co-workers:	□ close	☐ somewhat close	□ distan	t □ conflicted			

## Therapeutic History Describe any previous therapy you have participated in: Describe any hospitalizations you've had for mental health issues: If any family members have been treated for mental health issues, please describe: Describe any substance abuse/addiction treatment you've had: List any medications for mental health or addiction issues you are currently taking: \_\_\_\_\_ Prescribing physician (name, address, phone): Are there any other health concerns you feel are impacting your mental health: How Can Counseling Be of Help? Tell me what brings you here today: \_\_\_\_\_ Tell me about any significant loss or trauma you've experienced (recent or past): Tell me what your most important therapeutic goals are: \_\_\_\_\_\_ Are you currently experiencing any suicidal thoughts or feelings? ☐ Y ☐ N Are you currently experiencing any homicidal or violent thoughts or feelings, or anger-control problems? Y Are you concerned for your safety for any reason? ☐ Y ☐ N

Lynn Miller Counseling • 571 High Street • Worthington • Ohio • 43085 • (614) 702-7011

If you answered yes to any question above, please explain: \_\_\_\_\_

Emergency contact person (name, relationship, phone, address)