



**ADULT COUNSELING PATIENT QUESTIONNAIRE**

**PATIENT INFORMATION**

FULL NAME: \_\_\_\_\_

SEX:  Male  Female  Other: \_\_\_\_\_ BIRTHDAY: \_\_\_\_\_ AGE: \_\_\_\_\_

CELL PHONE \_\_\_\_\_

PRIMARY EMAIL ADDRESS: \_\_\_\_\_

PATIENTS PRIMARY ADDRESS: \_\_\_\_\_

How did you hear about us?

Website/Search  Doctor: \_\_\_\_\_  Friend: \_\_\_\_\_  Other: \_\_\_\_\_

What is your current employment status? \_\_\_\_\_

What is the highest level of education you have completed? \_\_\_\_\_

Marital/Relationship Status: \_\_\_\_\_

How many children or dependents do you have? \_\_\_\_\_

**MEDICAL INFORMATION**

Medical diagnoses:

\_\_\_\_\_

Does the patient have any allergies? If so, what happens when exposed?:

\_\_\_\_\_

\_\_\_\_\_

Pt's Primary Care Physician: \_\_\_\_\_

Address/Phone Number: \_\_\_\_\_

Pt's Specialist Physician if applicable: \_\_\_\_\_

Address/Phone Number: \_\_\_\_\_





Current physical health concerns (if applicable): \_\_\_\_\_

Hospitalizations/Surgeries:

\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:**

NAME	DOSAGE	FREQUENCY	METHOD

**\*IF YOU NEED MORE ROOM PLEASE FILL IT OUT ON THE BACKSIDE**

Any recent psychological testing?

\_\_\_\_\_

Professional Psychologist administering testing:

\_\_\_\_\_

Copy of results available?     YES     NO

**PSYCHOLOGICAL INFO:**

Any history of substance abuse?     YES     NO    What substance/How often: \_\_\_\_\_

Any history of trauma or abuse?     YES     NO





Have you had suicidal thoughts recently?  NEVER  RARELY  SOMETIMES  FREQUENTLY

Have you had them in the past?  NEVER  RARELY  SOMETIMES  FREQUENTLY

Have you intentionally inflicted any harm upon yourself?  YES  NO  UNSURE

If yes, how?  CUTTING  SUICIDE ATTEMPT  OTHER (specify):

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Are you a survivor of any type of trauma? For example, BUT NOT limited to: Miscarriage, loss of infant/child, foster/adoption incidence, pregnancy/birth complications, accident of any kind, relationship abuse (emotional, mental, physical), child abuse (emotional, mental, physical), experience a natural disaster, sexual abuse of any kind such as rape or molestation, etc. If so, please explain.

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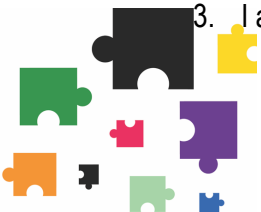
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How often do you feel lonely? Always Very Often Sometimes Rarely Never

How often do you feel depressed? Always Very Often Sometimes Rarely Never

Please state your level of agreement for the following statements: (Completely Agree, Agree, Neutral, Disagree, Completely Disagree)

1. I am content with the current state of my life. \_\_\_\_\_
2. Currently I don't need to worry about the finances in my life. \_\_\_\_\_
3. I am satisfied with my life. \_\_\_\_\_





4. I am happy with the relationships in my life. \_\_\_\_\_

5. I am happy with my professional life. \_\_\_\_\_

What are you hoping to accomplish in therapy?

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Any concerns or fears about therapy?

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What is your greatest strength?

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How would you describe your religious or spiritual beliefs and practices (if any)?

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Any additional information to add: \_\_\_\_\_

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CLIENT PRINT NAME

CLIENT SIGNATURE

DATE

