Psychotherapy Client Questionnaire

Name:_____ Date:_____

REFERRED BY:

Name:_____ Phone #:_____

Address:_____

May I inform this person that you have consulted with me?_____

_____
Your Signature

CONFIDENTIALITY STATEMENT:

Case records are strictly confidential. No outsider, not even your closest relative or family doctor, is permitted to see your case record without your written permission or a court order.

1. GENERAL

A. Name:_____

Address:_____

Home Phone:_____ Work Phone:_____

Fax:_____ E-Mail:_____

Age:_____ Date of Birth:_____ Place of Birth:_____

B. What is your present living situation? _____

_____

C. Names and ages of children

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

D. Give a short history of your closest interpersonal relationships:

_____

_____

_____

_____

_____

_____

_____

_____

Education: _____

Occupation: _____

Currently working: _____

What is your present job situation? _____

_____

2. PROBLEM AREA

A. State in your own words the nature and history of your chief complaint:

_____

_____

_____

B. Present interests, hobbies, activities: _____

_____

_____

_____

C. How is most of your free time occupied? _____

_____

_____

_____

_____

D. What are your life goals?_____

_____

_____

_____

_____

E. What are your five greatest fears?

1. _____

2. _____

3. _____

4. _____

5. _____

3. FAMILY HISTORY

A. Father's name:_____

Age:_____Health:_____

If deceased, age and cause of death:_____

_____

Your age at time of father's death:_____

Give a description of your father's personality:

_____

_____

_____

_____

_____

_____

_____

_____

B. Mother's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

_____

Your age at time of mother's death: _____

Give a description of your mother's personality:

_____

_____

C. Brothers/Sisters (Names, sex, age, and something about each):
[Are there significant others from your growing up years?]

D. Who are the most important people in your life? Describe.

Previous Medical, Psychiatric, and Psychotherapy Contacts

E. Have you ever been in psychotherapy before? _____

If yes, when? _____

May I contact your previous therapist(s)? _____

Therapist: _____

Address: _____

Phone: _____

Therapist: _____

Address: _____

Phone: _____

F. Have you ever been hospitalized for an emotional problem?

If yes, when, where, and how long? _____

_____

If yes, when, where, and how long? _____

_____

G. Have you ever made a suicide attempt? If yes, describe it, when, and the circumstances leading up to the attempt.

_____

_____

_____

_____

_____

H. Have any close relatives been treated for psychiatric problems?

If yes, please specify: _____

_____

I. Has any relative of yours committed suicide?

If yes, please specify: _____

_____

J. Give details of all forms of abuse you were subject to in childhood (neglect, verbal violence, sexual).

_____

_____

_____

K. Give a brief history of any litigation you have been involved in regarding child custody, divorce, liability, or medical malpractice.

4. SELF-DESCRIPTION

Give a word-picture of yourself. Describe yourself in terms of how you presently feel and see yourself (include both negatives and positives):

_____

_____

_____

_____

_____

_____

5. MEDICAL HISTORY

A. Have you had any of these childhood illnesses?

	NO	YES	DON'T KNOW
Measles	___	___	_____
Mumps	___	___	_____
Whooping cough	___	___	_____
Chicken pox	___	___	_____
Rheumatic fever	___	___	_____
Rubella (German measles)	___	___	_____

Please list all medical hospitalizations and operations. Give diagnoses and dates:

_____

_____

_____

(continue on reverse)

B. Have you ever suffered from any of the following illnesses?

	NO	YES	DATE OF ONSET
Cancer	___	___	_____
TB	___	___	_____
Diabetes	___	___	_____
Thyroid trouble	___	___	_____
Kidney trouble	___	___	_____
High blood pressure	___	___	_____
Eye trouble	___	___	_____
Heart trouble	___	___	_____
Neurological disease	___	___	_____
Ulcers	___	___	_____
Head injury	___	___	_____
D.T.'s	___	___	_____
Allergies	___	___	_____

List all allergies: _____

_____

Any other serious illnesses? _____

C. Family History

Have any of your blood relatives suffered from any of the illnesses listed above? If yes, please specify ailment and relative:

_____

_____

_____

Any other serious illness? _____

D. Drug/Medication History

Because many drugs (legal and illegal) have psychological effects, it is important for me to know what drugs you are *currently* taking and/or *have taken in the past.* This information will remain strictly confidential, but it is very important for me to know before you begin therapy so that an accurate assessment of your problem and situation can be made. Please list *all* legally prescribed and illegal drugs ever used (past or present) and describe how often you use them and what effects you seek:

_____

_____

_____

_____

_____

Have any of these drugs been prescribed by a physician?

Yes____ No____ If so, which drugs and for what reason?

_____

E. Nutrition

Is your diet unusual in any way? Yes____ No____

If so, how? _____

_____

F. Symptoms

Check any of the following symptoms that apply to you at this time. Also indicate when any of these symptoms have applied to you in the past.

Hair falling out _____
Weight gain _____
Fatigue _____
Constipation _____
Dry skin _____
Weakness _____
Weight loss _____
Tremor _____
Big appetite _____
Fast heart beat _____
Diarrhea _____
Poor appetite _____
Headaches _____
Dizziness _____

Fainting spells _____
Difficulty sleeping _____
Drinking too much fluid _____
Blurred vision _____
Deafness _____
Ringing in ears _____
Chest pain _____
Shortness of breath _____
Tingling of hands or feet _____
Ankle swelling _____
Indigestion _____
Nausea or vomiting _____
Urinary difficulties _____
Problems with sexual organs _____

G. Menstrual History, Issues, or Problems: _____

_____

_____

_____

_____

H. Smoking and Drinking

Do you smoke (anything)? _____ What? _____

How much? _____ Frequency? _____

Do you drink alcohol?_____If yes, how much?_____

What happens to you when you smoke or drink, that is, what does it do for you?

_____

_____

Describe any physical symptoms at all that you have when you smoke or drink.

_____

_____

I. What kind, and how much physical exercise do you get?

_____

_____

_____

J. Describe the spiritual/religious aspects of your life:

_____

_____

_____

_____

K. Have you ever been hypnotized? If so, for what and what were the results?

_____

_____

_____

_____

L. Have you ever been on worker's comp or disability? For what, how long, results?

_____

_____

_____

_____

M. In case of emergency, please notify one of the following three people: May I have your permission to inform one or all of these people if you are ever in danger?

Yes_____ No_____

1._____

Name	Daytime Phone	Evening Phone	Address

2._____

Name	Daytime Phone	Evening Phone	Address

3._____

Name	Daytime Phone	Evening Phone	Address

This questionnaire supplements previous informed consents.

_____ _____

Your Signature Date

_____ _____

Therapist's Signature Date

For Therapist Use Only!

Diagnostic Impressions: _____

Date

_____

_____

_____

Treatment Plan: _____

Date

_____

_____

_____

_____

Referrals:

_____ Date _____

_____ Date _____