

## Client Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Presenting Problem:** What are the problems that brought you here today?

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**Problem Check List:** Check (✓) mild, moderate or severe for all items concerning you. You may add comments.

Category/Problem	✓ <i>Mild</i>	✓ <i>Moderate</i>	✓ <i>Severe</i>	Comments
<b>Anxiety</b>				
Nervousness				
Mood swings				
Panic attacks				
<b>Depression</b>				
Crying; sadness				
Death or loss				
Fatigue; tiredness				
Feeling of failure				
Grieving or mourning				
Low energy or feelings of emptiness				
Thinking of harming or hurting myself				Refer to page 6
<b>Thought or thinking changes</b>				
Cannot concentrate				
Confusion				
Decision-making problems				
Cannot make decisions				
Mixed feelings				
Put off decisions				
Fears; phobias				
Guilt feelings				
Judgment problems				
Impulsiveness				
Loss of control				
Outbursts				
Memory problems				
Same thoughts over and over				
Seeing/hearing things that seem real, but am not sure				
Suspicious				
<b>Health problems</b>				Refer to pages 4-6
Menstrual (PMS; menopause)				
Headaches				
Pain				
Physical problems				

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Category	√Mild	√Moderate	√Severe	Comments
<b>Overdoing (excess) or Underdoing (deficit)</b>				
Alcohol use				Refer to page 4
Drug use				Refer to page 4
Prescription				
Over the counter				
Street				
Eating				
Overeating				
Undereating				
Dieting				Refer to page 5
Vomiting				
Weight problems				
Gambling				
Repeating actions over and over				
Risk taking				
Sleep				
Too much				
Too little				
Nightmares				
Tobacco use				
<b>Relationship Problems</b>				
Abuse				Refer to page 3
Recipient				
Hurting others or animals				
Anger; arguing; irritability				
Aggression; violence				
Dependent on others				
Feel inferior to others				
Lonely				
Stay away from people				
Sensitive to criticism				
Sensitive to rejection				
Friendship problems				
Interpersonal conflicts				
Divorce or separation				
Marital conflict				
Affairs				
Remarriage				
Parenting				
Child care/management				
Child custody				
Sexual problems				
Conflicts				
Desire change				
Function problem				

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Category/Problem	√Mild	√Moderate	√Severe	Comments
<b>Finance; Legal; School; Work</b>				
Career concerns; goals; Choices				
Financial problems				
Debt				
Low income				
Legal matters				
School learning problems				
Work problems				
Cannot keep job				
Overwork				
Unemployed				
<b>Problems with Self</b>				
Esteem				
Neglect or poor hygiene				
Perfectionist				
Negative thoughts				
Self-centered				
Shy				
Stress/or tension problems				
Self-control				
Low frustration tolerance				

Note: If a problem of yours is not listed, please explain on the back of this page.

**History of Relationships with Original Family--Please answer the following:**

My parents' relationship with each other was \_\_\_\_\_

My relationship with my biological mother was \_\_\_\_\_

My relationship with my biological father was \_\_\_\_\_

The number of stepfathers I have is \_\_\_\_ The number of stepmothers I have is \_\_\_\_

Brother/Sister	Name	Age	Tell something about each

(use back of paper as needed)

**History of Abuse as a Child and/or Adult—Please answer the following:**

\_\_\_ I *WAS NOT* abused in any way. \_\_\_ I *WAS* abused. (If yes, answer the next item)

Use this key to indicate the type of abuse—

E = emotional (humiliation) N = neglect (failure to be fed, sheltered and/or protected)

P = physical (beatings) S = sexual (touched; molested; fondled; intercourse)

V = verbal

Kind of abuse: \_\_\_\_\_

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**History of Education**--Please answer the following:

My highest grade completed was \_\_\_\_\_ My grades were usually \_\_\_\_\_

I was \_\_\_ was not \_\_\_ in special classes. Explain \_\_\_\_\_

**History of Military Service**—Answer if this section applies to you.

Dates		Branch of Military	Job Title or Duties
From	To		

Type of discharge: \_\_\_\_\_

**Marital or Relationship History and Current Status**

My present living situation is \_\_\_\_\_

I have been married \_\_\_ times. I have been divorced \_\_\_ times.

I get along with my present spouse or partner (describe) \_\_\_\_\_  
 \_\_\_\_\_

**Children (use back of page if more space is needed)**

Name	Age	Sex	Adjustment or other problems

I get along with my children (describe) \_\_\_\_\_  
 \_\_\_\_\_

**Medical**

List all medical hospitalizations and major surgeries (use back of page if more space is needed):

Age	Dates	Illness or diagnosis	Name and specialty of treating physician

List current, prescribed, medications (use back of page if more space is needed):

Medication	Dose	Reason taken

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My main medical problems of concern now are \_\_\_\_\_

**Family Medical History**

My father's health is \_\_\_ good, \_\_\_ fair, \_\_\_ poor; if deceased, his age at death was \_\_\_ and his cause of death was \_\_\_\_\_. My age at the time of his death was \_\_\_\_\_

My mother's health is \_\_\_ good, \_\_\_ fair, \_\_\_ poor; if deceased, her age at death was \_\_\_ and her cause of death was \_\_\_\_\_. My age at the time of her death was \_\_\_\_\_

**My Nutrition and Exercise**

My diet is unusual \_\_\_ no \_\_\_ yes. If yes, please explain \_\_\_\_\_

I drink \_\_\_ cups of coffee or tea daily. I drink \_\_\_ cans or bottles of soda or other sources of caffeine daily.

My weekly exercise consists of this kind or type \_\_\_\_\_ and amount \_\_\_\_\_

**My Chemical Use**

I smoke \_\_\_ chew \_\_\_ tobacco (what?) \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_

I describe myself as a social drinker \_\_\_ heavy drinker \_\_\_ alcoholic \_\_\_ a person with a drinking problem \_\_\_

I drink alcohol (how much?) \_\_\_\_\_ (how often?) \_\_\_\_\_

**Psychological Background**

I have received psychotherapy or counseling services \_\_\_ no \_\_\_ yes. If yes, indicate the following:

Dates	From whom?	For what?	Results?

I have taken medications for an emotional problem \_\_\_ no \_\_\_ yes. If yes, indicate the following:

Dates	Medication	Prescribed by whom	For what?	Results?

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I have been hospitalized for an emotional problem \_\_\_\_ no \_\_\_\_ yes. If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Dates	Where?	For what?	Results?

I have made a suicide attempt \_\_\_\_ No \_\_\_\_ Yes. If yes, describe what led to the attempt, when it occurred and what happened \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have close relatives that have been treated for psychological problems \_\_\_\_ No \_\_\_\_ Yes. If yes, describe \_\_\_\_\_  
\_\_\_\_\_

I have a relative that committed suicide. \_\_\_\_ No \_\_\_\_ Yes. If yes, describe \_\_\_\_\_  
\_\_\_\_\_

**Other** - comments pertaining to any category or part of this questionnaire.

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