New Psychotherapy Client Questionnaire

Please fill out this questionnaire as completely as possible. The information you provide will be very helpful in our work together. If you have any questions about any of the requested information, please let me know. Thank you!

Date _____

1. GENERAL

A. Full Name: _____

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: _____

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

_____

_____

_____

_____

_____

E. Education/Work

Education Level: _____

Occupation: _____

Employer: _____

What is your present job situation? _____

_____

F. Present interests, hobbies, activities: _____

_____

_____

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

_____

_____

2. PROBLEM AREA/GOALS

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

_____

_____

_____

_____

_____

_____

_____

_____

B. What are your life goals? _____

_____

_____

_____

_____

_____

_____

_____

C. 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):

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

4. PREVIOUS PSYCHIATRIC,AND PSYCHOTHERAPIC TREATMENT

A. Have you ever been in psychotherapy before? _____

If yes, when? _____

May I contact your previous therapist(s)? _____

Therapist (1) _____

Address _____

Phone _____

Therapist (2) _____

Address _____

Phone _____

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

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

_____

_____

C. Have you ever made a suicide attempt?

If yes, describe it, when, and the circumstances leading up to the attempt. _____

_____

_____

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

If yes, please specify: _____

_____

_____

E. Has any relative of yours committed suicide?

If yes, please specify: _____

_____

_____

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)	___	___	_____

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

_____

_____

_____

_____

_____

D. 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? _____

_____

E. 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? _____

_____

F. Nutrition

Is your diet unusual in any way? Yes _____ No _____

If so, how? _____

_____

_____

_____

_____

G. 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	_____	Fainting spells	_____
Weight gain	_____	Difficulty sleeping	_____
Fatigue	_____	Drinking too much fluid	_____
Constipation	_____	Blurred vision	_____
Dry skin	_____	Deafness	_____

Weakness	_____	Ringing in ears	_____
Weight loss	_____	Chest pain	_____
Tremor	_____	Shortness of breath	_____
Big appetite	_____	Tingling of hands or feet	_____
Fast heart beat	_____	Ankle swelling	_____
Diarrhea	_____	Indigestion	_____
Poor appetite	_____	Nausea or vomiting	_____
Headaches	_____	Urinary difficulties	_____
Dizziness	_____	Problems with sexual organs	_____

Other _____

_____

H. Reproductive History, Issues, or Problems: _____

_____

_____

_____

_____

I. 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? _____

_____

_____

J. Physical Activity

Do you exercise regularly? Yes _____ No _____

Please describe current/past activity levels and any concerns: _____

_____

_____

_____

_____

_____

K. Describe the spiritual/religious aspects of your life: _____

_____

_____

_____

_____

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

_____

_____

_____

6. 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): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

My signature below certifies that I have completed this questionnaire myself or with help from others that I solicited. I understand that this questionnaire supplements previous informed consents.

Signature: _____ Date: _____

(Client)