

Client Questionnaire

Client Name:		Today's Date:	
Mailing Address:			
E-Mail Address:		Phone Number(s):	
Would you like to receive appointment reminders by e-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No		Okay to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What's the easiest way to reach you?		Any limitations I should know about when contacting you?	
Date of birth:	Gender Identity:	Ethnic Identity:	
Emergency contact name:	Phone: E-Mail:	Relationship to you?	
By whom were you referred?	May I thank this person for their referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Occupation and place of work:			
What's the highest level of education you've completed (circle one)?	Middle School	High School	Undergraduate Graduate
What is your relationship status?	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other:		
Do you have any children? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, names and ages:		
Your children live with you: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> They do not live with me	Please describe custody arrangements (if applicable):		

Have you ever physically harmed yourself or someone else, or had thoughts of such harm?

Past: Yes No Current: Yes No

If yes, please describe:

Have you ever given serious thought to ending your own or someone else's life?

Past: Yes No Current: Yes No

If yes, please describe:

Have you ever made an attempt to end your life or someone else's life?

Past: Yes No Current: Yes No

If yes, please describe:

Do you own a gun?

Yes No

Are you experiencing violence or abuse at home, work, or in any other setting?

Yes No

If yes, please describe:

Are there any legal issues affecting you at this time?

Yes No

If yes, please describe:

Are you currently taking any medication? Yes No Dietary supplements? Yes No

If yes, please list names of medication/supplement, purpose, dosage, and frequency taken:

Are there any significant health issues affecting you?

Physician's name and phone number:

Are you currently under the care of any other health care providers? Yes No

What kind of provider(s)? MD LMT ND PMHNP LAc DC Other

Why are you seeking counseling at this time? What aspects of your life would you like to explore and/or change?

Please rate the level of distress the following issues have caused you within the past year (mark #1-4 next to each issue):

0	1	2	3	4
None	Minor	Moderate	Considerable	Extreme

- | | | |
|--|--|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Anger | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Cultural Concerns | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Drugs | <input type="checkbox"/> Eating | <input type="checkbox"/> Family |
| <input type="checkbox"/> Finances | <input type="checkbox"/> Grief or Loss | <input type="checkbox"/> Gender Identity |
| <input type="checkbox"/> Job | <input type="checkbox"/> Legal | <input type="checkbox"/> Obsessions/Compulsions |
| <input type="checkbox"/> Past Trauma | <input type="checkbox"/> Phobias | <input type="checkbox"/> Relational Conflict |
| <input type="checkbox"/> School | <input type="checkbox"/> Sexual Identity | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Spirituality | <input type="checkbox"/> Tobacco | <input type="checkbox"/> Violence/Abuse |
| <input type="checkbox"/> Health or Medical Condition | <input type="checkbox"/> Communication | |

Have you received counseling before? Yes No

Type, length of time and approximate dates:

How did you feel about the process? What helped, or not?

Describe your lifestyle habits:

Eating and nutrition:

Exercise and physical activity (times per week, type, duration):

Sleep (average number of hours per night, deep or light; ease or difficulty getting to sleep or staying asleep):

Substance use (frequency and amount of use):

Describe your social and community support:

Describe some of the things you enjoy doing, as well as some of things you do to take care of yourself or feel good:

What do you consider to be your skills and strengths?

Do you have any spiritual or religious beliefs that are important to you? Yes No. If yes, please describe:

Is there anything else you'd like me to know?

The information that I have provided on this form is true and accurate to the best of my knowledge:

Client Signature

Date

Would you like to receive occasional updates by e-mail about other offerings? (e.g. groups, workshops)? Yes No