Client Questionnaire

Name: _____ **Date**: _____

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

_____

_____

_____

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

Category/Problem	**√ *Mild***	**√ *Moderate***	**√ *Severe***	**Comments**
Anxiety				
Nervousness				
Mood swings				
Panic attacks				
Depression				
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
Thought or thinking changes				
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				
Health problems				Refer to pages 4-6
Menstrual (PMS; menopause)				
Headaches				
Pain				
Physical problems				

Continue on next page →

Category	√Mild	√Moderate	√Severe	Comments
Overdoing (excess) or Underdoing (deficit)				
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				
Relationship Problems				
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				

Continue to next page →

Category/Problem	√Mild	√Moderate	√Severe	Comments
Finance; Legal; School; Work				
Career concerns; goals; Choices				
Financial problems				
Debt				
Low income				
Legal matters				
School learning problems				
Work problems				
Cannot keep job				
Overwork				
Unemployed				
Problems with Self				
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: _____

Continue to next page →

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			
From	**To**	**Branch of Military**	**Job Title or Duties**

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

Continue to next page →

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?

Continue to next page →

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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