

**CLIENT INFORMATION**

The purpose of this questionnaire is to get a picture of your personal, family and marital background. Please answer the questions as accurately as you can and feel free to ask questions regarding the questionnaire at any time.

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

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_  
S.S.#: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Number: \_\_\_\_\_

Children: (Please check one) YES \_\_\_\_\_ NO \_\_\_\_\_  
(If yes) NAMES \_\_\_\_\_ AGES: \_\_\_\_\_

Live with you: FULL TIME \_\_\_\_\_ PART TIME \_\_\_\_\_

PHONE NUMBERS: HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

Can I call you at Home: Yes \_\_\_\_\_ No \_\_\_\_\_ Work: Yes \_\_\_\_\_ No \_\_\_\_\_ Cell: Yes \_\_\_\_\_ No \_\_\_\_\_

PLACE OF WORK: \_\_\_\_\_ Profession: \_\_\_\_\_

Email Address: \_\_\_\_\_

Can I email you at this address? Yes \_\_\_\_\_ No \_\_\_\_\_

WHO REFERRED YOU? \_\_\_\_\_ AGENCY: \_\_\_\_\_

EDUCATIONAL LEVEL (Please circle highest grade completed): 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

RELATIONSHIP STATUS: I am: in relationship \_\_\_\_\_ married \_\_\_\_\_ living with partner \_\_\_\_\_

Number of years in relationship to current partner \_\_\_\_\_

Previous marriages/partners (if any) and length of relationship \_\_\_\_\_

**FAMILY OF ORIGIN INFORMATION**

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_ Living or deceased \_\_\_\_\_

Health \_\_\_\_\_ Profession \_\_\_\_\_

Father's Name \_\_\_\_\_ Age \_\_\_\_\_ Living or deceased \_\_\_\_\_

Health \_\_\_\_\_ Profession \_\_\_\_\_

Write 3 positive adjectives to describe your Mother:

Write 3 negative adjectives to describe your Mother:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Write 3 positive adjectives to describe your Father:

Write 3 negative adjectives to describe your Father:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**CURRENT PROBLEM/ISSUES – describe**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please continue on the back of this page

HEALTH

1. Are you on any medication: (Please check one) YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, Please list NAMES OF MEDICATION, DOSAGE AND FREQUENCY TAKEN:

\_\_\_\_\_

2. When was your last check up? \_\_\_\_\_ Physician's Name \_\_\_\_\_

Physician Phone Number \_\_\_\_\_

3. HAVE YOU EVER GIVEN SERIOUS CONSIDERATION TO, OR ATTEMPTED TO, END YOUR OWN LIFE?

YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, please describe: \_\_\_\_\_

\_\_\_\_\_

4. In case of emergency please contact:

NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_

5. IS THERE A HISTORY IN YOUR FAMILY OF ANY OF THE FOLLOWING (Please check all that apply):

	YOU	PARTNER	CHILD(REN)	BRIEF EXPLANATION
ANXIETY				
DEPRESSION				
ALCOHOLISM/DRUGS				
ANGER				
WORKAHOLISM				
EATING DISORDER				
FOOD ADDICTION				
SPENDING/GAMBLING				
SEX ADDICTION				
SEXUAL ABUSE				
RAPE				
PHYSICAL ABUSE				
EMOTIONAL ABUSE				
VIOLENCE				
SLEEP DISORDERS				
PHYSICAL CONDITIONS				

6. Check all of the following areas which have been or are a problem for you? (Please check one for each area):

Marriage/partner	YES ___ NO ___	Family	YES ___ NO ___
Job/School	YES ___ NO ___	Health	YES ___ NO ___
Finances	YES ___ NO ___	Legal	YES ___ NO ___
Friendships	YES ___ NO ___	Mood	YES ___ NO ___
Anxiety Level	YES ___ NO ___	Eating habits	YES ___ NO ___
Spirituality	YES ___ NO ___	Anger	YES ___ NO ___
Alcohol	YES ___ NO ___	Drugs	YES ___ NO ___
Sexual Difficulties	YES ___ NO ___	Caffeine	YES ___ NO ___
Ability to control your temper	YES ___ NO ___	Smoking	YES ___ NO ___

Other areas not listed: \_\_\_\_\_

7. ADDITIONAL INFORMATION: Anything else you think I should know?

Thank you for taking the time to fill out this questionnaire