CLIENT INFORMATION QUESTIONNAIRE

Your cooperation in completing this questionnaire will be helpful in planning my services for you. Please answer each item carefully. Ask me for clarification if you do not understand an item.

Full name _____ Date _____

Address _____
_____
_____

Home Phone (___) _____ May a voicemail be left on this number Y/N

Work Phone (___) _____ May a voicemail or text be left on this number Y/N

Email Address _____ May your counselor send you and email at this address Y/N

Age _____ D.O.B. _____/_____/_____ Male/Female (circle)

Marital status (circle one):

Single Married Separated Divorced Remarried Widowed Other

Occupation: His _____ Hers _____

Gross annual income: His _____ Hers _____

Circle highest level of education:

Grade school Middle school High school Some college
Bachelor's degree Master's degree Advanced degree (Ph.D., M.D., etc.)

Religious preference: His _____ Hers _____

Where do you attend?

Briefly describe your reason(s) for seeking help

_____
_____
_____

Who suggested you contact us? _____

Have you ever consulted a professional counselor? YES NO

If yes, Name _____ When _____

Address _____
_____

Who is your physician _____

Are you presently taking any medication? YES NO
If yes, please list

_____
_____
_____
_____

Do we have your permission to contact your physician in order to coordinate services?
YES NO

List any health problems for which you currently receive treatment
_____
_____
_____
_____

Have you ever considered suicide? YES NO

Have you ever attempted suicide? YES NO If so, when _____

Circle any of the following which are presently causing you difficulty:

Assertiveness	Health problems	Career choices	Stomach problems
Parenting	Alcohol use	Legal matters	Self-concept
Bowels	Sexual Problems	Marriage	Religion
Nightmares	Loneliness	Concentration	Separation
Bed-wetting	Ulcers	My thoughts	Suicidal thoughts
Nervousness	Energy	Sleep	Decision making
Children	Parents	Insomnia	Education
Divorce	Relaxation	Ambition	Asthma
Temper	Depression	Shyness	Stress
Inferiority	Friends	Dating	Memory
Drug Use	Headaches	Tiredness	Finances
Appetite	School	Unhappiness	Fears
Work	Confusion	Premarital	Food
Self-control	Sadness	In-laws	My past
Guilt	Allergies	Abuse	

Now, put an * by the **TWO** circled items that are causing you the **MOST** difficulty.

If never married, circle and skip this section: Never Married

Please give your marital history:

1st marriage: Date began Ended Name of spouse _____

Children and ages

2nd marriage: Date began Ended Name of spouse _____

Children and ages

3rd marriage: Date began Ended Name of spouse _____

Children and ages

4th marriage: Date began Ended Name of spouse _____

Children and ages

List the members of your family and all others living in your home:

Name(s) Age / Birth Date Relationship Occupation

_____
_____
_____
_____
_____
_____
_____
_____

Who has custody of the minor children living in your home _____

Is your family or anyone in your family currently involved with any of the following agencies/institutions If yes, please give name and explanation.

Department of Human Services YES NO _____

Legal Aid YES NO _____

Children's Home/Ranch YES NO _____

Department of Corrections YES NO _____

Probation or parole YES NO _____

(Officer's name)

Attorney (Name) YES NO _____

Other (please specify)

_____
_____
_____
_____