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NEW CLIENT INFORMATION QUESTIONNAIRE

DATE_____ NAME_____

ADDRESS_____

CITY_____ ZIP CODE_____

DATE OF BIRTH_____ AGE_____ EMAIL_____

HOME #_____ Cell#_____

MESSAGE: YES / NO EXPLAIN IF NO:_____

EMERGENCY CONTACT:_____

HOME/CELL#_____

YOUR EMPLOYER_____ PHONE_____

YOUR OCCUPATION_____

SPOUSE/PARTNER NAME_____DOB_____

SPOUSE EMPLOYER_____

SPOUSE OCCUPATION_____

LIST ALL OTHERS LIVING WITH YOU:

NAME	AGE	RELATIONSHIP	OCCUPATION:

HEALTH INSURANCE COVERAGE (If I am to bill it) COPAY_____DEDUCTIBLE_____ DED . MET?

INSURANCE COMPANY_____

PHONE # ON BACK OF CARD_____

NAME OF INSURED_____ GROUP NUMBER_____

(NAME, ADDRESS, PHONE) (POLICYHOLDER) _____

_____

POLICYHOLDER DATE OF BIRTH: (if different than above) _____

POLICYHOLDER ID#_____

RELATIONSHIP OF POLICYHOLDER TO YOU_____

PROVIDE THE SAME INFORMATION FOR ANY SECONDARY INSURANCE YOU HAVE:

_____

19. Have you ever been prescribed medication for emotional/psychiatric issues?

Yes *_____ No_____ * If yes, please list current medications below:

Medication	Prescribing Physician	Reason?	How long taken?

Have you ever been hospitalized for emotional, psychiatric, or addiction problems?

(please circle) Yes No

Number of times: _____ Length of time of last hospitalization: _____

Reason for last hospitalization: _____

Have you ever attempted suicide? (please circle) Yes No

Number of times: ____ Approximate date(s) of attempt(s):_____

_____

Person or agency that referred you: _____

If no referral, how did you hear about me?_____

Below is a list of issues for which people may seek counseling. Please circle the number to the right that best describes how much that issue has been problematic for you during the past 7 days, including today. Circle only one number for each issue and complete all items.

0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely

1. Living situation	0	1	2	3	4
2. Feeling nervous or tense	0	1	2	3	4
3. Anger	0	1	2	3	4
4. Worrying	0	1	2	3	4
5. Unable to concentrate	0	1	2	3	4
6. Shyness	0	1	2	3	4
7. Stress	0	1	2	3	4
8. Grief/Bereavement	0	1	2	3	4
9. Feeling blue	0	1	2	3	4
10. Spells of terror or panic	0	1	2	3	4
11. Feeling lonely	0	1	2	3	4
12. Guilt	0	1	2	3	4
13. Fearful or afraid	0	1	2	3	4
14. Feeling hopeless	0	1	2	3	4
15. Feeling worthless	0	1	2	3	4
16. Annoyed or irritated	0	1	2	3	4
17. Feeling out of control	0	1	2	3	4
18. Feeling you can’t trust others	0	1	2	3	4
19. Feeling others are out to get you	0	1	2	3	4

20. Feeling others dislike you	0	1	2	3	4
21. Feeling others are talking about you	0	1	2	3	4
22. Unpleasant thoughts	0	1	2	3	4
23. Thoughts of suicide	0	1	2	3	4
24. Thoughts of hurting someone else	0	1	2	3	4
25. Blaming others	0	1	2	3	4
26. Decision making	0	1	2	3	4
27. Acting impulsively	0	1	2	3	4
28. Not remembering things	0	1	2	3	4
29. Crying easily	0	1	2	3	4
30. Alcohol or drug use	0	1	2	3	4
31. Seeing things others don't see	0	1	2	3	4
32. Hearing voices others don't hear	0	1	2	3	4
33. Sleep difficulties	0	1	2	3	4
34. Nightmares	0	1	2	3	4
35. Overeating	0	1	2	3	4
36. Poor appetite	0	1	2	3	4
37. Concerns about food or eating	0	1	2	3	4
38. Chronic illness	0	1	2	3	4
39. Physical pain	0	1	2	3	4
40. Headaches	0	1	2	3	4
41. Stomach problems	0	1	2	3	4
42. Tired/Low energy	0	1	2	3	4
43. Fainting or dizziness	0	1	2	3	4
44. Shaking or trembling	0	1	2	3	4

45. Self-esteem	0	1	2	3	4
46. Identity	0	1	2	3	4
47. Values	0	1	2	3	4
48. Being a parent	0	1	2	3	4
49. Your children's problems	0	1	2	3	4
50. Your parents	0	1	2	3	4
51. Problems with friends	0	1	2	3	4
52. Separation/Divorce	0	1	2	3	4
53. Spouse/Partner	0	1	2	3	4
54. Verbal abuse	0	1	2	3	4
55. Physical abuse	0	1	2	3	4
56. Sexual abuse	0	1	2	3	4
57. Pregnancy	0	1	2	3	4
58. Abortion	0	1	2	3	4
59. Sexual concerns or disinterest	0	1	2	3	4
60. Unemployment	0	1	2	3	4
61. Job dissatisfaction	0	1	2	3	4
62. Career/education concerns	0	1	2	3	4
63. Finances	0	1	2	3	4
64. Time management	0	1	2	3	4
65. Legal matters	0	1	2	3	4
66. Racial issues	0	1	2	3	4
67. Other concerns (please describe below):	0	1	2	3	4

_____

_____

Rank in order your three biggest concerns today:

1. _____

2. _____

3. _____

WHEN WERE YOU LAST EXAMINED BY A PHYSICIAN? _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

LIST ANY MAJOR HEALTH PROBLEMS FOR WHICH YOU CURRENTLY RECEIVE TREATMENT:

_____

_____

_____

HAVE YOU EVER RECEIVED PSYCHIATRIC OR PSYCHOLOGICAL HELP OR COUNSELING OF ANY KIND?_____. IF SO, PLEASE LIST WHEN,_____

WHERE, WHOM YOU SAW AND THE PURPOSE:_____

_____

_____

PLEASE ADD ANY ADDITIONAL INFORMATION WHICH YOU THINK MAY BE USEFUL

_____

_____

_____

_____

_____

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE BRING IT TO YOUR FIRST APPOINTMENT. A MORE IN DEPTH ASSESSMENT WILL BE COMPLETED WITH YOU DURING OUR FIRST APPOINTMENT.

YOUR SIGNATURE _____DATE_____