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CLIENT INFORMATION QUESTIONNAIRE

I would like to gather some background information from you before we begin working together. Your completion of it will help us make the best use of our first appointment and help me better understand your situation. Thank you.

Name _____ Today's Date _____ _____ _____
First MI Last

_____ Age _____ Date of Birth _____ _____ _____
Preferred Name

I. CONTACT INFORMATION

Address _____

City _____ State _____ Zip _____

Cell Phone _____ *May I Call/ Leave a Message?* **Y N** *May I text this Number?* **Y N**

Email _____ *May I email you?* **Y N**

II. EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Phone _____

III. INSURANCE INFORMATION

Insurance _____ ❑ Check Box if insurance card has been provided and skip to next section

Relationship to primary insurance holder ❑ Self ❑ Child ❑ Spouse ❑ Other_____

Name of primary insurance holder _____

Address _____ State _____ Zip _____

Subscriber/ID#: _____ Group Number _____

IV. REFERRAL INFORMATION How did you hear about my practice of psychology?

How did you hear about my practice of psychology? (Specify below)

❑ Internet Search ❑ Psychology Today or specify:_____

❑ Another professional _____
Physician, psychiatrist, psychologist, social worker, etc.

❑ Other _____
Specify: family member, friend, advisor, teacher, business card, etc.

V. EMPLOYER INFORMATION

Are you employed? ❑ No (skip to next section) ❑ Yes

Employer _____ Occupation _____

How many hours a week do you work? ❑ Full Time ❑ Part time (specify hours) _____

Address _____ City _____

State _____ Zip _____ Work Phone _____

May I Call this Number? **Y N** *May I Leave a Message?* **Y N**

VI. ACADEMIC INFORMATION

Are you enrolled as a student? ❑ No (skip to next section) ❑ Yes

How many credits are you currently taking? _____ GPA _____

Are you on academic probation/leave of absence? ❑ Probation ❑ Leave of absence

University Status ❑ First ❑ Second ❑ Third ❑ Fourth /Senior ❑ Grad/Professional

Major / Specialization _____ Expected Graduation Year _____

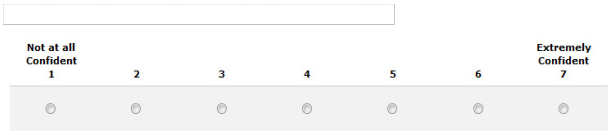
VII. DEMOGRAPHIC INFORMATION

Please describe yourself as fully as you feel comfortable.

Gender Identity
(e.g., female, male, cisgender, transgender, gender queer, non-binary, uncertain, etc.)

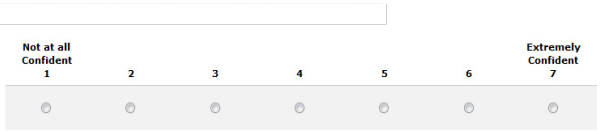
Preferred pronouns:

Gender Confidence Scale



Sexual Orientation
(e.g., Straight, Gay, Lesbian, Bisexual, Pansexual, Queer, Uncertain, etc.)?

Sexual Orientation Confidence Scale



Relationship Status (check all that apply)

❑ Single ❑ Engaged ❑ Partnered ❑ Open/Poly/Non-Monogamous
❑ Married ❑ Separated ❑ Divorced ❑ Remarried ❑ Widowed

Religious Affiliation / Spirituality

Do you have a religious or spiritual preference? ❑ No ❑ Yes (specify)

To what extent does your religious or spiritual preference play an important role in your life?

❑ Very Important ❑ Important ❑ Neutral ❑ Unimportant ❑ Not applicable

Disability Status

Do you identify as having a disability? ❑ No ❑ Yes (specify)

Military Service ❑ Yes ❑ No

Have you ever been, or are you currently, enlisted in any branch of the US military (active duty, veteran, national guard or reserves)? In what capacity?

Did your military experiences include any traumatic or highly stressful experiences that continue to bother you (e.g., war, combat, injuries, death, natural disasters, foreign deployment, etc.)? ❑ Yes ❑ No

VIII. MEDICAL INFORMATION - Most Recent Provider(s) and Rx

Physician _____ ❑ Primary Care ❑ Psychiatrist

Address _____ City _____

State _____ Phone _____ Fax _____

Physician _____ ❑ Primary Care ❑ Psychiatrist

Address _____ City _____

State _____ Phone _____ Fax _____

Are you currently taking any prescription medication? ❑ No ❑ Yes

Name of Medication	Date Began Taking	Dose / Times per Day	Condition Being Treated	Name of Prescribing Professional

Have you suspended a medication because of side effects? ❑ No ❑ Yes (Please list)

IX. CURRENT & PREVIOUS COUNSELING EXPERIENCES

Have you previously sought counseling for mental health concerns? ❑ No ❑ Yes

Therapist Name	Dates Seen	Concerns Worked On

Please indicate if/when you have had the following experiences (Check one per row): Have you ever....	Never	In the Last Year	Over a Year Ago	Both
Experienced a traumatic event that caused you to feel intense fear, helplessness, or horror?				
Been hospitalized for mental health concerns?				

Experiences continued (check one per row)	**Never**	**In the Last Year**	**Over a Year Ago**	**Both**
Received treatment for alcohol or drug use?				
Purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, etc.)?				
Seriously considered attempting suicide?				
Made a suicide attempt? If yes, how many times?				
Considered seriously injuring another person?				
Intentionally physically harmed another person?				
Had unwanted sexual contact or experience?				
Felt you had an eating problem?				
Been prosecuted for criminal activity?				
Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, authority figure)?				

X. FAMILY INFORMATION

Please list the people you consider to be part of your family.

Name	**Age** D = deceased	**Occupation**	**Mental health problems or diagnoses:**
Spouse / Partner			
Mother			
Father			
Stepparent			
Stepparent			
Siblings			
Others			

Are you or your parents currently involved in any divorce or child custody proceedings? ❑ Yes ❑ No

List people you consider to be of significant support to you.

Name	**Relationship** Friend, Aunt, Uncle, Roommate, etc	**Contact Info** Release Required

With whom are you currently living? ❑ Family ❑ Alone
❑ Roommates ❑ University Res Hall ❑ Off-Campus ❑ Greek
❑ Other _____

XI. PRESENTING CONCERNS

Please check all the following symptoms that you have experienced in either the last month or more than a month ago. Please check both if you have experienced the symptoms recently and in the past:

☐ = **Recent** (within the last month) ○ = **Past** (one month ago or longer)

- ☐ ○ change in appetite
- ☐ ○ significant weight gain/loss
- ☐ ○ change in mood
- ☐ ○ irritability
- ☐ ○ feelings of worthlessness
- ☐ ○ changes in sleeping patterns
- ☐ ○ loss of energy
- ☐ ○ loss of interest in activities
- ☐ ○ loss or decrease in sexual interest
- ☐ ○ lost or irregular menstrual cycle
- ☐ ○ increase of energy
- ☐ ○ difficulty concentrating
- ☐ ○ nightmares- bad dreams every so often
- ☐ ○ problems with attention, motivation, memory, concentration
- ☐ ○ recurrent or excessive anxiety or worry
- ☐ ○ feelings of restlessness
- ☐ ○ trembling or shaking
- ☐ ○ accelerated heart rate
- ☐ ○ shortness of breath
- ☐ ○ sweating
- ☐ ○ chest pain
- ☐ ○ nausea
- ☐ ○ recurrent thoughts of death
- ☐ ○ recurrent thoughts of harming others
- ☐ ○ seeing things that others do not
- ☐ ○ hearing voices that others do not
- ☐ ○ paranoid thoughts
- ☐ ○ substance use (pot, alcohol or drugs)
- ☐ ○ odd or unusual experiences

Self-Harm

In the last month, have you had thoughts of killing yourself? ❑ Yes ❑ No

If yes, what is the frequency?

❑ Rarely ❑ Sometimes ❑ Frequently ❑ Always

What is the duration?

❑ Seconds ❑ Minutes ❑ Hours ❑ Constant

What is the intensity?

❑ Brief and fleeting ❑ Focused deliberation ❑ Intense rumination

Substance Use - In the past 2 weeks, how many times have you used …

Alcohol 5 or more alcohol-based drinks in a row (males); or 4 more in a row (females)?

❑ None ❑ Once ❑ Twice ❑ 3-5 Times ❑ 6-9 Times ❑ 10+ times

Marijuana

❑ None ❑ Once ❑ Twice ❑ 3-5 Times ❑ 6-9 Times ❑ 10+ times

Other recreational drugs

❑ None ❑ Once ❑ Twice ❑ 3-5 Times ❑ 6-9 Times ❑ 10+ times

If more than once, what other recreational drugs have you used in the last two weeks?

Tobacco or any nicotine product

❑ None ❑ Once ❑ Twice ❑ 3-5 Times ❑ 6-9 Times ❑ 10+ times

Please mark all of the items below about which you are concerned. Feel free to indicate which of these items you would especially like to work on in therapy.

- ❑ Aggression, Violence
- ❑ Alcohol / Marijuana / Drugs / Rx Misuse
- ❑ Anger, Irritability
- ❑ Anxiety, Panic Attacks, Social Anxiety
- ❑ Career Choices
- ❑ Cultural Adjustment/Acculturation
- ❑ Death of a Loved One
- ❑ Depression
- ❑ Discrimination / Oppression
- ❑ Divorce / Separation
- ❑ Eating Disorders / Body Image Concerns
- ❑ Fears / Phobias
- ❑ Fertility Concerns
- ❑ Finances
- ❑ Flashbacks
- ❑ Gambling
- ❑ Gender Identity
- ❑ Internet Porn
- ❑ Isolation / Loneliness
- ❑ Legal Concerns
- ❑ Obsessions / Compulsions
- ❑ Parenting
- ❑ Perfectionism
- ❑ Physical Health
- ❑ Relationship Concerns
- ❑ Recovery Support from Addiction
- ❑ Self-Esteem, Self-Image
- ❑ Self-Harm / Self-Mutilation
- ❑ Sexual Dysfunction / Sexual Intimacy
- ❑ Sexual Harassment / Sexual Assault / Title IX
- ❑ Sexual Identity
- ❑ Spiritual / Religious Matters
- ❑ Stress
- ❑ Suicidal Thoughts
- ❑ Trauma
- ❑ Other(s):

_____

Please state the reason(s) and/or concern(s) for which you are seeking counseling:

What are your goals or hopes for therapy?

Thank you for taking the time to fill out this confidential questionnaire