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New client questionnaire

Welcome! Please tell me about yourself

Date: ___________ Name: ____
Date of Birth: _______________ Age: ___________ Gender: ______________________
Address: ____
City, State, Zip Code: ____

Phone:______________________________ Alternate phone: _____________________
Best times to reach: _______________________ Email: _________________________
Which way/s may I contact you confidentially? _________________________________
How did you find me? ____
Whom may I thank for a referral? ____

Have you had any major life changes and stressors in the past year?
____

What brings you to therapy at this time? ____________________________________
____
____

Please think about this carefully before our first session:
What would you like to be different in your life by the end of our sessions? _________
____
____

Current work and relationships:
Who is your current employer? ____
What kind of work do you do? ____

Your relationship status (married, single, significant partner)? __________________
Do you have children? (Names, ages) _____________________________________
Your living arrangements – roommates, children, partner, spouse_______________
____

Emergency Contact Name: ____

Phone Number: ________________________ Relationship to you ________________

Medical & prescriptions:

Name and phone of your primary care doctor _________________________________

Name and phone of your psychiatrist or prescriber ____________________________

Mental Wellness

Name ____ Date _____________

Are you taking medications that help your mental wellness? Yes No

If so, which? ____

Have you taken medications for mood in the past? Yes No

If so, which ones? ____

Have you seen a therapist or psychiatrist in the past? Yes No

When? Was it helpful and in what way? ________________________

____

Have you ever been hospitalized for mental health? Yes No

If so when? ___________ For what symptoms? _________________

____

Past and present mental health diagnoses?

____

Have you ever had a head injury? Yes No

If so, did you have changes in your cognitive abilities or learning style?

____

Do you ever see or hear things that aren't there? Yes No

Have you ever intentionally hurt yourself? By cutting? Or? Yes No

Have you ever tried to kill yourself? Yes No

Have you ever had periods of your life where you felt like you didn't need to sleep, engaged in risky, compulsive behaviors? Yes No

Are you feeling depressed, hopeless or apathetic? Yes No

If so since when? ____

Are you feeling anxious? Yes No

If so, since when? ____

Have you ever had panic attacks? Yes No

____

Do you drink alcohol? Yes No

If so, what kind and how much?

____

Do you use marijuana? Yes No

If so, how frequently? ____

Do you use unprescribed drugs? Yes No

If so, what kind and frequency?

____

Have you ever sought treatment for a substance use problem? Yes No

____

Is there anything else you would like me to know?

____