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CLIENT QUESTIONAIRE

For billing purposes and to help us get started please provide me with the following information:

Your name: _____ Date: _____

Address: _____ Date of birth: _____

_____ Referred by: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Email:

_____

Education level: _____ Occupation:_____

Place of employment:_____

If you are consulting me about a child please provide the child's name:

_____ Age: _____ Date of birth: _____

Should I need to contact you where can I leave you a message: _____

Please list the other people, if any, who are living in your household:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency contact information: _____

How do you intend to pay for treatment? ☐ cash ☐ check ☐ charge ☐ insurance

Have you/your child ever been in therapy treatment before: ☐ no

☐ yes When and for how long? _____

What was the focus of treatment?

_____

_____

Name of treating therapist(s): _____

_____

Are you/your child currently seeing a therapist? ☐ no ☐ yes

Have you/your child ever been hospitalized for mental or emotional problems? ☐ no

☐ yes Why? _____

When and for how long? _____

Name of treating therapist: _____

Are you/your child currently taking any prescription medications? ☐ no

☐ yes Medications: _____

Prescribed by whom?_____

For how long have you/your child been on the medication(s)?_____

Have you/your child ever taken any medications for a mental or emotional condition? ☐ no

☐ yes For how long? _____

Have you/your child ever attempted suicide? ☐ no

☐ yes When? _____

Describe the circumstances that led to that attempt:_____

_____

_____

Are you/your child currently having any suicidal thoughts? ☐ no

☐ yes Please describe:_____

_____

_____

Have you/your child ever experienced verbal, physical, emotional, sexual abuse? ☐ no

☐ yes Please describe:_____

_____

_____

Have you/your child ever been a victim of a violent crime? ☐ no

☐ yes Please describe: _____

_____

_____

_____

Have you/your child ever been diagnosed with a serious illness? ☐ no

☐ yes Please describe: _____

_____

_____

_____

Please describe you/your child's overall health today: _____

_____

_____

_____

Have you ever been in a 12-step program? ☐ no

☐ yes Please describe: _____

_____

_____

Do you smoke? ☐ no ☐ yes How much? _____ For how long? _____

Do you drink alcohol? ☐ no ☐ yes How much do you consume in a week? _____

Have you in the past or do you currently use illegal drugs? ☐ no

☐ yes Please describe your use: _____

_____

_____

Name of insurance company: _____

Name of person whose name is on the policy: _____

Address of person whose name is on the policy:

_____

_____

Date of birth:_____ Home phone: _____

Place of employment: _____

Insurance policy #: _____ Group # _____

Telephone # : _____