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CLIENT HISTORY QUESTIONNAIRE

Name: ________________________________ Date: ______________

Date of birth: ____________ Age: _____

Address: ______________________ City: ________________ State: ______ Zip: ________

Best number(s) to reach you: ____

E-mail(s): ____

Primary reason(s) for seeking services:

Anger management	Coping problems	Moodiness/Irritability	Depression	Anxiety
Occupational problems	Fears/Phobias	Parenting concerns	Relationship problems	Alcohol/Drugs
Sleeping problems	Trauma/Abuse	Compulsive behaviors	Family problems	Social problems

Other mental health concerns (specify): ____

Family Background

With whom do you live at this time? ____

Please circle all that apply: *Single* *Married* *Separated* *Divorced* *In a relationship* *Living together*

If married or in a relationship, for how long? ____

If separated or divorced, for how long? ____

Current relationships

Spouse/Partner: ____

Children: ____

Mother: ____

Father: ____

Siblings: ____

Occupational/Education/Social History

Education

Highest level of education completed: _______________________ Military Experience: No Yes__________________

Did you experience learning problems as a student? No Yes, please explain: ____________________________________

Current occupation: ___________________________________

Do you like your work? No Yes, please explain: ____

Social

Please describe your significant friendships and current social support network. _________________________________

____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, reading, sports, outdoor activities, church, etc.)

Activity	How often?

Medical/Physical Health

List any current health concerns: ____________________

List any recent health or physical changes: ____________________

Recent changes in appetite? None Increased Decreased   Recent significant weight change: Yes No

List any hospitalizations, significant accidents, surgeries, head injuries, etc. ____________________

____

Primary Doctor/Practice Name: ____________________

All prescribed/herbal/over the counter medications	Dose	Dates	Purpose	Side effects

Psychological/Psychiatric Treatment History

	No	Yes	When	Where/With Whom	Purpose
Therapy					
Suicide attempts					
Drug/Alcohol treatment					
Psychiatric Hospitalizations					
Psychological testing					

Substance Use History

How often do you drink alcohol? ________

How often do you use drugs for recreational purposes? ________

What drugs do you use? ____________________

How old were you when you first used alcohol and/or drugs? ____

Is there a history in your family of alcohol and/or drug dependence? No Yes, please explain: ____________

Does your use of alcohol and/or drugs have a negative impact on your relationships or occupation?

No Yes, please explain: ____________________

Current Behavioral/Emotional Symptoms

Please circle any of the following that are typical for you:

Easily frustrated	Sadness/Depression	Alcohol/Drug use	Moodiness	Aggression	Withdrawal
Social anxiety	Impulsivity	Sleeping problems	Panic attacks	Nightmares	Phobias
Hallucinations	Excessive worry	Irritability	Hopelessness	Sexual problems	Anger
Sleeping problems	Eating disorder	Suicidal thoughts	Suicide attempts	Low self-esteem	Tics

Other, please describe: ______________________________

Have you experienced the death of a friend, pet, family member, etc? No Yes, please describe: ______________________________

____

As a child, did you experience abuse or neglect? No Yes, please explain: ______________________________

____

As an adult, have you experienced assault, abuse, or domestic violence? No Yes, please explain: ______________________________

____

Have there been any other recent significant events or changes in your life (car accident, new home, moving, fire, new school, etc.)? No Yes, please explain: ______________________________

Is there a history of suicide attempts or completed suicide in your family? No Yes, please explain: ______________________________

____

Are you suicidal at this time? No Yes, please explain: ______________________________

What are your goals for therapy? ______________________________

Please use this page to provide any additional information that you believe would assist in treatment.