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# Initial Client Questionnaire

Client name: _____ Date of Birth: _____

How did you hear about me? _____

What is the reason for your appointment today?_____

How many psychotherapists/counselors have you seen in past for this problem and related problems? _____

What has been your past experience in psychotherapy/counseling so far?_____

Have you ever been diagnosed with a mental illness? ☐ Yes / ☐ No

Are you presently in psychotherapy/ counseling with anyone? ☐ Yes / ☐ No
If Yes, Who?

Any previous psychological testing? _____ Do you have reports? ____

Have you been hospitalized for psychiatric problems? ☐ Yes / ☐ No. If yes, how many times?___ .
When was the last time?_____

What is your opinion of psychiatric medications? _____

How many psychiatrists have you seen previously for medication management? _____

What has been your experience with medication so for? _____

Have you attempted suicide in the past? ☐ Yes / ☐ No

Do you physically hurt yourself? ☐ Yes / ☐ No

Do you have thoughts of seriously harming yourself or others now? ☐ Yes / ☐ No

Your highest education level: _____

| ***Symptoms:*** | ***YES*** | ***NO*** |
|---|---|---|
| Have you been down, depressed, or hopeless in the past month? | | |
| Are you bothered by little interest or pleasure in doing things? | | |
| Has your appetite changed (eating more or less)? | | |
| Has your sleep been disturbed (insomnia or over-sleeping)? | | |
| Do you feel worthless or guilty? | | |
| Do you have sudden or unexpected bouts of anxiety or nervousness? | | |
| ***Do you often feel tense, worried, or stressed?*** | | |
| Do you have acute onset of symptoms such as palpitations, shortness of breath, or trembling? | | |
| Do you worry about a lot of different things? | | |
| Do you avoid placed or situations because of anxiety or worry? | | |
| Do you have recurrent, persistent or unwanted thoughts or do repetitive behaviors? | | |
| Have you been through any significantly stressful periods on the past 6 months? | | |
| In your lifetime, have you faced any potentially life-threatening events such as natural disaster, serious accident, physical or sexual assault/abuse, military combat or child abuse? | | |
| Since you experienced any of these stressors, have you been easily startled? | | |
| Angry or irritable? | | |
| Emotionally numb or detached from your feelings? | | |
| Prone to physical reactions when reminded of the event? | | |
| Do you use prescription medicines or street drugs to relax, calm your nerves, or get high? | | |
| Have you made an effort to cut down on your drinking or drug use? | | |
| Have you been annoyed by people who criticize your drinking or drug use? | | |
| Do you ever feel guilty about your drinking or drug use? | | |
| Do you ever drink or use drugs to steady your nerves, get rid of a hangover, or relieve withdrawal symptoms? | | |

Your occupation / work: _____

Did you have a happy childhood? ☐ Yes / ☐ No

Where you raised by your parents? ☐ Yes / ☐ No

How was your relationship with your parents growing up? _____

How is your relationship with your parents now? _____

Were you abused or molested as a child? ☐ Yes / ☐ No

How many times have you been married? _____

Who do you presently live with? _____

Do you have any children? If so, how many? _____

Are there major problems in your present household?_____

Who is supportive of you at this time?_____

Are you facing any legal difficulties at this time? ☐ Yes / ☐ No

How much difficulty are you having presently in functioning at your work/ home life/school?
_____

What religious and spiritual values are important to you? _____

What are some of your strengths and abilities? _____

What are some of your needs? _____

Do you have any specific preferences for your care ? Yes __ No __

*If yes, please describe:* _____

**Substance Use history:**

| Substance | Age at First Use | Date/Age at Last Use | Duration & Frequency of Use |
|---|---|---|---|
| Alcohol | | | |
| Marijuana | | | |
| Methamphetamines | | | |
| Amphetamines | | | |
| Cocaine | | | |
| Benzodiazepines | | | |
| Barbiturates | | | |
| Hallucinogens | | | |
| Opiates (Prescription) | | | |
| Methadone | | | |
| Heroin | | | |
| PCP (Angel Dust) | | | |
| Inhalants | | | |
| Prescription Drugs | | | |
| Other illicit Substances | | | |
| Caffeine | | | |
| Tobacco (smoking/chewing) | | | |

Have you ever had treatment for substance-abuse? ☐ Yes / ☐ No

Do you have any medication allergies? ☐ Yes / ☐ No; If yes, describe: _____

Environmental/food allergies? ☐ Yes / ☐ No; If yes, describe: _____

**Family history of psychiatric illness:**

| Problem/Illness | In Which Family Member |
|---|---|
| Nervous breakdown | |
| Depression | |
| Bipolar disorder | |
| Anxiety/panic | |
| Drug abuse | |
| Alcohol abuse | |
| Suicide with a gun | |
| Suicide (other) | |
| Violent crime | |
| Survivor of abuse | |
| Abuser or Molester | |

**Circle all problems present now or in past:**

| | | | |
|---|---|---|---|
| Allergies | Asthma | Chronic cough/bronchitis | Snoring |
| Chest pain | Heart problems | Palpitations | Mitral valve prolapse |
| Swelling of feet | High blood pressure | Thrombosis | On blood thinners |
| Problem with urination | Miscarriages | Sexual problems | Sexually Transmitted Diseases |
| Abortions | HIV | Weight gain | Weight loss |
| Diarrhea | Constipation | Liver problems | Heartburn/indigestion |
| Stroke | Headaches | Ringing in ears | Hearing aids |

| | | | |
|---|---|---|---|
| Vision problems | Thyroid problems | Infections | TB |
| Genetic Problems | Diabetes mellitus | High sensitivity to medications | Seizures |
| Nausea and vomiting | Arthritis/muscle pains | Numbness or tingling | Other problems: |

**Family history of physical illness:**

| Problem/Illness | In Which Family Member |
|---|---|
| Diabetes | |
| Heart disease | |
| Sudden-death | |
| Other major illness | |

Who is your Primary Care Physician? _____

Other doctors seen regularly: _____

Current non-psychiatric medications: _____

_____

Is there any other information you would like your therapist to be aware of?

_____

_____

_____

_____