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New Client Questionnaire

(To be completed by the client)

Name: ____ D/O/B: _________ Age: ______

Sex: __________ Race: __________________________ Religion preference: _______________________

Referred by: ____

(e.g. Name of physician, website, friend/family member, etc.)

Primary reason(s) for seeking service: ____

____

____

Family

Marital status: ❒ Married ❒ Separated ❒ Divorced ❒ Widowed

❒ Living together ❒ Engaged ❒ Committed relationship ❒ Single

Length of current marriage/relationship: ____

Reason for separation/divorce: ❒ N/A ____

Parenthood: ❒ N/A ❒ # of children: _________ Ages/gender: ___________________________

____

Child/children live with whom? ____

I feel safe in my current living situation ❒ Yes ❒ No Please describe: _________________________

____

I feel safe in my current relationship ❒ Yes ❒ No Please describe: _____________________________

____

Growing up, I was raised by/lived with: ____

____

I get along with my siblings: ❒ N/A ❒ Yes ❒ No because: __________________________

____

I get along with my parents (or other caregivers): ❒ N/A ❒ Yes ❒ No because: ______________

____

____

Name: ____ Date: __________

Development

Are there any special, unusual, or traumatic experiences that affected your life/development?

____

____

____

I have been (check all that apply): ❒ emotionally abused ❒ physically abused

❒ sexually abused ❒ abandoned ❒ N/A

Comments: ____

____

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often …
   Swear at you, insult you, put you down, or humiliate you? OR
   Act in a way that made you afraid that you might be physically hurt? ❒ Yes ❒ No
2. Did a parent or other adult in the household often …
   Push, grab, slap, or throw something at you? OR
   Ever hit you so hard that you had marks or were injured? ❒ Yes ❒ No
3. Did an adult or person at least 5 years older than you ever…
   Touch or fondle you or have you touch their body in a sexual way? OR
   Try to or actually have oral, anal, or vaginal sex with you? ❒ Yes ❒ No
4. Did you often feel that …
   No one in your family loved you or thought you were important or special? OR
   Your family didn't look out for each other, feel close to each other, or support each other?
   ❒ Yes ❒ No
5. Did you often feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? OR
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ❒ Yes ❒ No
6. Were your parents ever separated or divorced? ❒ Yes ❒ No
7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her? OR
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? OR
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   ❒ Yes ❒ No
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   ❒ Yes ❒ No
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   ❒ Yes ❒ No
10. Did a household member go to prison? ❒ Yes ❒ No

Social relationships

I usually get along with adults: ❒ Yes ❒ No because: ______________________________

____

____

Name: ____ Date: __________

I usually get along with children: ❒ Yes ❒ No because: ______________________________

____

____

I have friends: ❒ No ❒ Yes #__________ Males #__________ Females

Sexual orientation: ________________________ Comments: ________________________

I am sexually active: ❒ Yes ❒ No I have been sexually active: ❒ Yes ❒ No

I practice safe sex: ❒ N/A ❒ Yes, type(s) of contraceptive(s):

❒ No because:____

____

Cultural/ethnic

With which cultural, racial, or ethnic group do you identify? ________________________

Are you experiencing any concerns related to cultural, racial or ethnic issues? ❒ No ❒ Yes

If yes, please describe: ____

____

Religious/spiritual affiliation: ____

Would you like your spiritual/religious beliefs incorporated into therapy? ❒ No ❒ Yes

If yes, please describe: ____

____

Legal

I have been/am involvement with the Legal System: ❒ No ❒ Yes because: ______________

____

____

Education/employment

Highest level of education completed (including school name and diploma/degree (if applicable):

____

____

Are you currently enrolled as a student? ❒ No ❒ Yes

I like school: ❒ N/A ❒ Yes ❒ No because: ______________________________

____

My grades are usually (check all that apply): ❒ N/A ❒ A ❒ B ❒ C ❒ D ❒ F

My in school conduct is usually: ❒ N/A ____________________________________

____

Name: ____ Date: __________

In school/at work I have trouble with (check all that apply): ❒ N/A

❒ Memory ❒ Attention/Concentration ❒ Understanding some subjects/tasks

Which subjects/tasks? ____

❒ Other: ____

____

Sometimes I get into physical fights: ❒ No ❒ Yes because: ____________________

____

I am employed by: ❒ N/A ____

My job title is: ❒ N/A ____

I enjoy my job: ❒ N/A ❒ Yes ❒ No I have been employed/unemployed for (time):

____

I have never been employed outside the home: ❒

Military experience (i.e., branch, type of discharge, combat experience, etc.): ❒ N/A __________

____

Medical/physical health

I have the following medical problems: ____

____

____

(List all current medical issues including past accidents, surgeries, medical issues that may still affect you)

I take the following prescription or over the counter medications including vitamins, supplements, and herbs:

Name of medicine:	Reason

(Use additional space at bottom/back of this page if needed)

Please describe any recent changes in sleep, eating, behavior, weight, energy level, and/or mood:

____

____

____

Name: ____Date: ____________

Substance use history

I have used the following types of alcohol/illegal substances/tobacco: put an * by your drug of choice. ❐ N/A

Name of drug:	Age of first use:	Amount/frequency:	Date of last use:

Use additional space at bottom/back of this page if needed.)

Are you or someone you love concerned about your use of alcohol or drugs?

❐ Yes ❐ No ❐ N/A

Have you ever sought help (inpatient or outpatient treatment, 12-step program, SMART recovery, etc.) for substance abuse or addiction? ❐ Yes ❐ No ❐ N/A

If yes, please explain: ____

____

Please list any family history of alcohol or drug abuse: ____

____

Previous treatment history

I have cut, burned, scratched, hurt myself (including problems with eating): ❐ No ❐ Yes

because: ____

____

I have tried to kill myself before: ❐ No ❐ Yes because: ___________________________________

____

How? ____

____When was your last attempt? ____________

Are you currently feeling suicidal? ❐ No ❐ Yes If yes, please explain: __________________________

____

I have thought about killing someone else: ❐ No ❐ Yes because: ______________________________

____

Are you currently feeling homicidal? ❐ No ❐ Yes If yes, please explain: _________________________

____

Have you ever heard, seen, or felt things that others cannot hear, see or feel? ❐ No ❐ Yes

If yes, please describe: ____

____

Name: ____Date: ____________

I have had previous treatment (e.g., in-patient psych, private therapist, residential treatment, PHP/IOP):

❒ No ❒ Yes If yes, please explain: ____

____

____

If you have previously seen a therapist, what did you like or dislike about the experience: ________________

____

____

Types of Coping Skills (e.g., reading, writing, meditating, self-injury, substances, etc.)

I use: ____

____

For fun I like to (leisure/recreational activities): ____

____

I am willing to receive therapy: ❒ No because: _____________________________________

❒ Yes because: ____

What are your expectations or goal for therapy? ______________________________________

____

____

Please list any other information that might be helpful in understanding you or assist you in therapy:

____

____

Others things that are important for you to know about me:

____

____

____

____

Client or Legal Guardian Name: ____

Client or Legal Guardian Signature: ____

Date: __________________________