CLIENT INFORMATION

The purpose of this questionnaire is to get a picture of your personal, family and marital background. Please answer the questions as accurately as you can and feel free to ask questions regarding the questionnaire at any time.

Date:_____

NAME:_____ AGE:_____

ADDRESS:_____ DATE OF BIRTH:_____
_____ S.S.#:_____

Children: (Please check one) YES_____ NO_____
(If yes) NAMES _____ AGES:_____
_____ _____
Live with you: FULL TIME_____ PART TIME_____
PHONE NUMBERS: HOME_____ WORK_____ CELL _____
Can I call you at Home:Yes_____ No_____ Work:Yes_____ No_____ Cell: Yes ____ No ____
PLACE OF WORK:_____ Profession: _____
Email Address: _____
Can I email you at this address? Yes _____ No _____

WHO REFERRED YOU?_____ AGENCY: _____
EDUCATIONAL LEVEL (Please circle highest grade completed): 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

RELATIONSHIP STATUS: I am: in relationship ____ married _____ living with partner _____
Number of years in relationship to current partner _____
Previous marriages/partners (if any) and length of relationship _____

FAMILY OF ORIGIN INFORMATION
Mother's Name _____ Age_____ Living or deceased _____
Health _____ Profession _____

Father's Name _____ Age_____ Living or deceased _____
Health _____ Profession _____

Write 3 positive adjectives to describe your Mother:

1. _____
2. _____
3. _____

Write 3 negative adjectives to describe your Mother:

_____
_____
_____

Write 3 positive adjectives to describe your Father:

1. _____
2. _____
3. _____

Write 3 negative adjectives to describe your Father:

_____
_____
_____

CURRENT PROBLEM/ISSUES – describe

_____
_
_____
_
_____
_

Please continue on the back of this page

HEALTH

1. Are you on any medication: (Please check one) YES_____ NO_____

IF YES, Please list NAMES OF MEDICATION, DOSAGE AND FREQUENCY TAKEN:

_____

2.When was your last check up?_____ Physician's Name_____

Physician Phone Number_____

3.HAVE YOU EVER GIVEN SERIOUS CONSIDERATION TO, OR ATTEMPTED TO, END YOUR OWN LIFE?

YES_____NO_____

IF YES, please describe:_____

_____

4. In case of emergency please contact:

NAME:_____

PHONE:_____

5. IS THERE A HISTORY IN YOUR FAMILY OF ANY OF THE FOLLOWING (Please check all that apply):

	YOU	PARTNER	CHILD(REN)	BRIEF EXPLANATION
ANXIETY				
DEPRESSION				
ALCOHOLISM/DRUGS				
ANGER				
WORKAHOLISM				
EATING DISORDER				
FOOD ADDICTION				
SPENDING/GAMBLING				
SEX ADDICTION				
SEXUAL ABUSE				
RAPE_				
PHYSICAL ABUSE				
EMOTIONAL ABUSE				
VIOLENCE				
SLEEP DISORDERS				
PHYSICAL CONDITIONS				

6. Check all of the following areas which have been or are a problem for you? (Please check one for each area):

Marriage/partner	YES___NO___	Family	YES___NO___
Job/School	YES___NO___	Health	YES___NO___
Finances	YES___NO___	Legal	YES___NO___
Friendships	YES___NO___	Mood	YES___NO___
Anxiety Level	YES___NO___	Eating habits	YES___NO___
Spirituality	YES___NO___	Anger	YES___NO___
Alcohol	YES___NO___	Drugs	YES___NO___
Sexual Difficulties	YES___NO___	Caffeine	YES___NO___
Ability to control your temper	YES___NO___	Smoking	YES___NO___

Other areas not listed:_____

7. ADDITIONAL INFORMATION: Anything else you think I should know?

Thank you for taking the time to fill out this questionnaire