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ADULT CLIENT QUESTIONNAIRE

Thank you for taking the time to fill out this questionnaire. If there are questions you don't feel comfortable answering, just let me know and we can discuss them in session.

General Information

Name _____ Date _____

Home address _____

_____

Email _____

May I contact you via email regarding:

Responding to your email?	○ Yes	○ No
Appointment times and dates?	○ Yes	○ No
Upcoming groups or workshops?	○ Yes	○ No

Phone numbers	Is it okay to leave a message?	
Cell _____	○ Yes	○ No
Home _____	○ Yes	○ No
Work _____	○ Yes	○ No

Date of birth _____ Age _____

Intimate relationship status (Check any that apply.)

○ Single	○ Partnered	○ Married	○ Relationship recently ended
○ Divorced	○ Separated	○ Widowed	○ Relationship recently begun

Others living in your home (e.g. family member, partner, roommate, animal companion)

_____

_____

_____

Referred by _____ Relationship _____

May I thank them for the referral? ○ Yes ○ No

Emergency Contact Information

Name _____

Address _____

Cell phone _____ Home phone _____ Relationship to you _____

Name _____

Address _____

Cell phone _____ Home phone _____ Relationship to you _____

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Occupation, Education and Income

Current occupation (Check any that apply.)

○ Unemployed ○ Employed full-time ○ Employed part-time ○ Self-Employed
○ Student ○ Stay-at-home parent ○ Caretaker ○ Retired

Occupation(s) _____

_____

_____

_____

Work address(es) (If different from home address) _____

_____

_____

Current household income _____

How do you intend to pay for therapy? ○ Cash ○ Check

Education (Check all that apply.)

○ Preschool ○ Kindergarten ○ Elementary School ○ Middle School/Junior High
○ Boarding School ○ Homeschool ○ Un-school ○ High School or Equivalent

If in elementary, middle or high school, indicate grade level _____

College degree(s) _____

_____

Trade/professional/art school(s) _____

_____

Other specialized training _____

_____

Special interests, hobbies, avocations _____

_____

Personal strengths _____

_____

_____

How would you describe yourself in terms of race, ethnicity, culture, gender, orientation, religion/spirituality? _____

_____

_____

_____

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Family of Origin and Background

Parent's name ______________________________
Is this your ○Mother ○Father ○Partner of mother ○ Partner of father
○Stepmother ○ Stepfather ○ Other (Please specify) ______________
Is this parent still living? ○ Yes ○ No Age/health of parent ______________
Please briefly describe your relationship with this parent ______________
____
____

Parent's name ______________________________
Is this your ○Mother ○Father ○Partner of mother ○ Partner of father
○Stepmother ○ Stepfather ○ Other (Please specify) ______________
Is this parent still living? ○ Yes ○ No Age/health of parent ______________
Please briefly describe your relationship with this parent ______________
____
____

Parent's name ______________________________
Is this your ○Mother ○Father ○Partner of mother ○ Partner of father
○Stepmother ○ Stepfather ○ Other (Please specify) ______________
Is this parent still living? ○ Yes ○ No Age/health of parent ______________
Please briefly describe your relationship with this parent ______________
____
____

Parent's name ______________________________
Is this your ○Mother ○Father ○Partner of mother ○ Partner of father
○Stepmother ○ Stepfather ○ Other (Please specify) ______________
Is this parent still living? ○ Yes ○ No Age/health of parent ______________
Please briefly describe your relationship with this parent ______________
____
____

Sibling's name ______________________________ Age ________
Sibling's name ______________________________ Age ________
Sibling's name ______________________________ Age ________
Sibling's name ______________________________ Age ________

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Sibling's name _____ Age _____

Sibling's name _____ Age _____

Other siblings, significant family members _____

_____

_____

Describe your relationship with your siblings and other close family members. _____

_____

_____

_____

_____

_____

Do you have children? ○ Yes ○ No

Child's name _____ Age _____
Gender of Child ○ Female ○ Male ○ Transgender ○ Non-binary

Child's name _____ Age _____
Gender of Child ○ Female ○ Male ○ Transgender ○ Non-binary

Child's name _____ Age _____
Gender of Child ○ Female ○ Male ○ Transgender ○ Non-binary

Child's name _____ Age _____
Gender of Child ○ Female ○ Male ○ Transgender ○ Non-binary

Child's name _____ Age _____
Gender of Child ○ Female ○ Male ○ Transgender ○ Non-binary

How would you describe your relationship with your child/ren?

_____

_____

_____

_____

_____

Do you have animal companions? ○ Yes ○ No

Names and species of animal companions. Describe relationships. _____

_____

_____

_____

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Current Symptoms

Please check any of the following symptoms or problems that you are currently experiencing.

- ○ Depression
- ○ Moodiness
- ○ Fatigue
- ○ Difficulty concentrating
- ○ Crying more than usual
- ○ Loss of motivation, interest
- ○ Sleeping too much/little
- ○ Feeling guilty
- ○ Feeling worthless or hopeless
- ○ Suicidal thoughts
- ○ Suicidal plan, intent, actions
- ○ Decrease in energy
- ○ Withdrawal
- ○ Anxiety/fear/worry
- ○ Panic attacks
- ○ Avoiding being in public
- ○ Avoiding social situations
- ○ Phobias
- ○ Increase in energy
- ○ Insomnia
- ○ Difficulty falling asleep
- ○ Waking up too early
- ○ Nightmares
- ○ Sleep terrors
- ○ Increase in appetite
- ○ Decrease in appetite
- ○ Weight gain
- ○ Weight loss
- ○ Feeling foggy-headed
- ○ Problems remembering things
- ○ Intense menstrual periods
- ○ Perimenopause
- ○ Menopause
- ○ Parent-child conflict (self)
- ○ Marital/partner problems
- ○ Parent-child conflict (spouse/partner)
- ○ Sibling problems
- ○ Extended family problems
- ○ Violence in family, current (actual/threatened)
- ○ Violence in family, history (actual/threatened)
- ○ Recent traumatic experience
- ○ History of trauma
- ○ Other relationship problems
- ○ Anger/temper issues
- ○ Communication difficulties
- ○ Alcohol abuse
- ○ Drug abuse
- ○ Job/school problems
- ○ Financial concerns
- ○ Sexual problems
- ○ Sexual abuse (current/past)
- ○ Physical abuse (current/past)
- ○ Legal problems
- ○ Gambling issues
- ○ Death of a loved one
- ○ Eating/food issues
- ○ Major losses/changes in life
- ○ Body image issues
- ○ Low self-esteem
- ○ Confusion about life, career
- ○ Stomach/digestive problems
- ○ Migraine headaches
- ○ Head injury
- ○ Chronic pain
- ○ Intrusive thoughts
- ○ Compulsions (e.g., lock checking)
- ○ Disturbing thoughts
- ○ Seeing things others don't see
- ○ Hearing things others don't
- ○ Thinking others are out to get you
- ○ Dangerous/oppressive neighborhood
- ○ Dangerous/oppressive workplace
- ○ Age-based discrimination
- ○ Race-based discrimination
- ○ Ethnicity-based discrimination
- ○ Nationality-based discrimination
- ○ Gender-based discrimination
- ○ Ability-based discrimination
- ○ Orientation-based discrimination
- ○ Religion-based discrimination
- ○ Workplace pollution
- ○ Overwork
- ○ Underemployment
- ○ Insecure job
- ○ Concern about the environment, climate change
- ○ Acculturation challenges
- ○ Recent move
- ○ Recent job loss
- ○ Recent divorce or break-up
- ○ Lack of social supports

○ Other (please specify) _____

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Current Level of Functioning

Please circle the number that best indicates your current level of functioning. "0" indicates that you are not functioning or coping at all, while "10" means that you are coping better than you ever have.

◄ ---------- ►

0 1 2 3 4 5 6 7 8 9 10

Medical History

Please check any of the following problems you are currently experiencing or have experienced in the past.

○ Asthma	○ Diabetes	○ Ulcers	○ Migraines, Headaches
○ Epilepsy	○ Seizures	○ Lupus	○ Stroke
○ Cancer	○ Heart Condition	○ Multiple Sclerosis	○ Digestive Issues
○ Head Injury	○ Thyroid	○ Drug Allergies	○ Gynecological Problems

○ Other _____

If you answered "yes" to any of the above, please explain briefly _____

_____

_____

_____

_____

Have you ever been diagnosed or treated for Major Depression? ○ Yes ○ No

Have you ever been diagnosed or treated for Bipolar Disorder? ○ Yes ○ No

Have you ever been diagnosed or treated for Schizophrenia? ○ Yes ○ No

Previous hospitalizations (Please list date and reasons.) _____

_____

_____

_____

Have you had any previous suicide attempts? ○ Yes ○ No

If "yes," please list attempt(s), date(s) and method(s) _____

_____

_____

_____

Please list all current medications, including prescriptions, vitamins, herbal supplements and over-the-counter medication and dosage _____

_____

_____

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When was your last physical exam? Women's wellness exam?

Have you ever been diagnosed with hyperthyroidism (overactive thyroid), hypothyroidism (underactive thyroid), Hashimoto's Thyroiditis, Cushing Syndrome/Disease, Addison's, other issues with endocrine systems? If so, have you seen a physician regarding treatment of the issue? Please explain.

Have you ever or are you currently experiencing a vitamin or mineral deficiency? If so, have you seen a physician regarding treatment of the issue? Please explain.

Have you ever or are you currently experiencing heavy menstrual bleeding or other reproductive system issue? If so, have you seen a physician regarding treatment of the issue? Please explain.

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Family Medical History

Please list any major medical problems in your family _____

Has any family member been treated for Schizophrenia? ○ Yes ○ No
Has a family member been treated for Bipolar Disorder? ○ Yes ○ No
Has a family member been treated for Major Depression? ○ Yes ○ No
Has a family member been treated for Substance Abuse? ○ Yes ○ No
If "yes," please specify who and when:

Stressors

What would you consider to be your primary stressors at this time?

Lifestyle

Do you exercise? ○ Yes ○ No If yes, explain. _____

Describe your eating habits? _____

Describe your work/self/family/social balance? _____

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Describe your social life? _____

_____

How much time do you spend outdoors? _____

Do you smoke cigarettes? ○ Yes ○ No Packs per day? _____

Do you drink alcohol? ○ Yes ○ No Drinks per day? _____

Have you ever been treated for alcohol abuse? ○ Yes ○ No

If "yes" please explain. _____

_____

Do you use drugs? ○ Yes ○ No If yes, which drugs do you use? _____

_____

How often do you use drugs? _____

How much do you take at once? _____

Have you ever been treated for substance abuse? ○ Yes ○ No

If "yes" please explain. _____

_____

Do you use caffeine? ○ Yes ○ No How much per day? _____

Have you ever had legal charges brought against you? ○ Yes ○ No

If "yes" please explain (include charges and dates)_____

_____

Are there any guns or weapons in your home? ○ Yes ○ No

Support

Who/what would you consider to be a source of support for you at this time?

Family members _____

_____

Friends _____

_____

Groups or organizations _____

_____

Online communities _____

Religious/Spiritual affiliations _____

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Other _____

How do you practice self-care? _____

_____

_____

Psychotherapy/Counseling Experience

Have you ever been in therapy/counseling before? ○ Yes ○ No

If "yes," when you were in therapy? _____

_____

_____

Why were you in therapy and why did you stop? _____

_____

_____

What did you find most helpful about your previous therapy/counseling experience? _____

_____

_____

What did find unhelpful in your previous therapy/counseling experience? _____

_____

_____

What are your hopes/goals/intentions for therapy at this time? _____

_____

_____

_____

_____

_____

_____

_____

I, _____ consent to participate in therapy.

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(Printed Name)

(Signature)	**(Date)**
(Parent/Guardian Signature if client under age 18)	**(Date)**

I, _____ consent to participate in therapy.
(Printed Name)

(Signature)	**(Date)**
(Parent/Guardian Signature if client under age 18)	**(Date)**