## CONFIDENTIAL CLIENT QUESTIONNAIRE

**Name** ____________________________________ **Today's date** ______________

**Address** _______________________________ **City** ________________ **Zip** _________

**Phone c)** ____________________; **w)** ___________________; **h)** ________________

Your completion of this questionnaire provides me with some information about your life experiences, which helps me to know some of your history without taking valuable session time to gather this information. Please feel free to fill in what you feel would be helpful to me to know for this process. This completed questionnaire will become a part of your confidential therapy record, unavailable to anyone else.

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Date of birth _____________ Age ________ Referred by ______________________________

May I send a thank you to the referring person? Yes _____ No _____

Occupation ____________________ Present employer ________________________________

If you are using insurance, I will make a copy of your insurance card. Employer of the insured if different from your employer __________________________________________________

Have you had any previous counseling in the past five years? ____________________________

**Marital and living arrangements**

Check which of the following apply to you: Single_____ Engaged_____ Married_____

Divorced_____ Separated_____ Remarried_____ Widowed_____ Committed partnership_____

Please list all people who are presently living with you. Indicate their relationship to you and their ages. Below that, please list any children who are not living with you.

At home: __________________________________________________________________

_________________________________________________________________________

Away from home: ____________________________________________________________

_________________________________________________________________________

**Social support**

What kind of connection and support do you have from the following people:

Family ____________________________________________________________________

Friends ___________________________________________________________________

People at work _____________________________________________________________

People you see in leisure activities ____________________________________________

Church or spiritual groups ____________________________________________________

Organizations_______________________________________________________________

Who are the most important people in your life? _______________________________________

Do you have satisfying relationships with friends of both genders? ________________________

Do you have any difficulties making or keeping friends? _________________________________

What activities and interests do you presently have? _____________________________________

_________________________________________________________________________________

**Health habits and history**

Average number of hours of sleep per night? _____ Trouble falling asleep? _____ Awakening during the night? _____ Trouble falling back to sleep? _____ Do you awaken too early, too late or on time in the morning? _______________ Do you awaken rested? _____ Is eating an issue for you? _____ If yes, please explain _________________________________________________

If you drink coffee, how many cups per day? _____ How many cups of other beverages such as colas that contain caffeine per day? _____ If you drink alcohol, how much per week? _________

Do you use other mind altering substances? _____ Do you have compulsions, obsessions, or addiction of any kind? _______________________________________________________________

List any health conditions for which you are currently being treated: ________________________

_________________________________________________________________________________

Name any serious injuries/illnesses/surgeries and age they occurred: ________________________

_________________________________________________________________________________

Dates and circumstances of any sizable weight gain or loss: _______________________________

What was your reaction to your physical appearance as:

A child_______________________________ An adolescent _______________________________

A young adult _________________________ At present ___________________________________

Are you taking any medications? _____ If you are taking medications for anxiety, depression or other psychologically related concerns, please list: ______________________________________

Who is the prescribing physician? ____________________________________________________

How is your general energy level on a 10 point scale, 10 meaning superb? __________________

**Spiritual orientation**

What is most significant about your experiences and beliefs? _____________________________

_________________________________________________________________________________

## Childhood and family background

Father's name _______________ If living, where? ______________________ If living, what age now? ______ If deceased, year of death? _______ Cause of death ______________________

What was/is his occupation? __________________ What was/is his personality like?

_______________________________________ Describe your relationship with him during your

childhood ______________________________ adolescence ________________________________

present ________________________________

Mother's name ________________ If living, where? _______________________ If living, what age now? ______ If deceased, year of death? _______ Cause of death ______________________

What was/is her occupation? ___________________ What was/is her personality like? ________________________________________ Describe your relationship with her during your

childhood ______________________________ adolescence ________________________________

present ________________________________

Are your parents living together? _____ Do you have step parents? ______ If so, since what age? ______ If so, names of step parents ____________________________________________________

| Names of siblings | Sister/Brother | Age | Your relationship with each sibling | |
|---|---|---|---|---|
| | | | Past | Present |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

For what and how were you disciplined as a child and by whom? ___________________________ _____________________________________ For what and how were you praised as a child and by whom? _____________________________________________ How were you nurtured and by whom? _____________________________________________ Did anyone ever touch you inappropriately? If so, who and when? ________________________________________________

Is there any history of alcohol or other substance abuse in your family? _______ If yes, who was/is involved and please describe: ___________________________________________________

Is there any history of psychological/psychiatric treatment in your family? ______ If yes, who was/is involved and please describe ___________________________________________________

Have there been any suicides in your family? _____ If so, who and when? __________________

Have there been any significant losses in your life? If so, who or what and when? ____________ __________________________________________________________________________________

Please complete the sentences with regard to your childhood:

I feared losing __________________________________________________________________

When I was hurt, I _______________________________________________________________

What made me angry most often was ________________________________________________

When I was angry I would ____________________________________________________

I was most afraid of ________________________________________________________

One childhood secret of mine was ____________________________________________

I felt most secure when ____________________________________________________

I secretly wished I could __________________________________________________

**Sexual history**

Your parent's attitudes toward sex ___________________________________________

When and how did you gain your first information about sex? ____________________

Did anyone ever touch you inappropriately or hurt you in sexual ways? ______ If "yes" or "not sure" at what age? ______ Age at first intercourse? _____ Age of partner? _____ Your reactions? ______________________________ Have you had any gay or lesbian or bisexual experiences? ______ Age(s)? ______ Reactions? _____________________________________________

**Educational history**

Highest grade or degree completed? ___________ Describe your attitudes about going to school through the highest grade/degree completed? __________________________________________

Are you presently a student? ______ Where? ______________ Studying what? _____________

**Employment history**

What employment have you most enjoyed? _________________________ Why? ____________ ___________________________________ What employment have you least enjoyed? __________ ___________________________________ Why? _________________________________________

What is your feeling about your present work situation? _______________________________

**Self descriptive information**

What five words would you choose to describe yourself? ________________________________ ___________________________List your five main fears: ________________________________

What are your greatest strengths? ___________________________________________________

What about yourself would you most like to change? ____________________________________ ______________________________________________________________________________

What hopes do you have for the outcome of therapy for yourself? _________________________ ______________________________________________________________________________

What beliefs do you hold about yourself or life that would most help you to achieve those goals? ______________________________________________________________________________

Is there anything else that you would like for me to know? ______________________________ ______________________________________________________________________________

Or questions that you would like to ask? ____________________________________________