

## INDIVIDUAL CLIENT INFORMATION QUESTIONNAIRE

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully. All information is held in strictest confidence.

Name \_\_\_\_\_ Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of someone we may contact in case of an emergency: \_\_\_\_\_

Phone Number \_\_\_\_\_ His/Her relationship to you \_\_\_\_\_

Your Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status \_\_\_\_\_

### Employment

Are you currently employed? \_\_\_Yes \_\_\_No

Current Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Length of time employed: \_\_\_\_\_ Job responsibilities: \_\_\_\_\_

Level of stress of job: \_\_\_\_\_ Other jobs you have worked:

### Legal

Are you involved in any legal activities (civil, criminal, custody, probation/parole, etc.)? \_\_\_Yes \_\_\_No

If yes, please describe:

Past History:

Traffic violations: \_\_\_Yes \_\_\_No DUII/DWI, etc: \_\_\_Yes \_\_\_No

Felony/Misdemeanor charges? \_\_\_Yes \_\_\_No Civil/custody lawsuits: \_\_\_Yes \_\_\_No

### Military Experience

Military experience? \_\_\_Yes \_\_\_No (If no, skip this section)

Branch of Service: \_\_\_\_\_ Date enlisted/drafted: \_\_\_\_\_

Discharge date: \_\_\_\_\_ Type of discharge: \_\_\_\_\_ Rank at discharge: \_\_\_\_\_

Combat experience? \_\_\_Yes \_\_\_No Other stressors experienced: \_\_\_\_\_

Briefly describe your reason for seeking help \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who suggested you contact us? \_\_\_\_\_

**MEDICAL INFORMATION**

Current Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

When was your most recent complete physical examination? \_\_\_\_\_

Have you suffered from any of the following medical conditions during your lifetime?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> A serious accident | <input type="checkbox"/> Surgery             | <input type="checkbox"/> Allergies                      |
| <input type="checkbox"/> A head injury      | <input type="checkbox"/> Meningitis          | <input type="checkbox"/> Hospitalizations               |
| <input type="checkbox"/> High fevers        | <input type="checkbox"/> Hearing problems    | <input type="checkbox"/> Headaches                      |
| <input type="checkbox"/> Vision problems    | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Loss of consciousness          |
| <input type="checkbox"/> Ear infections     | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pregnancy/miscarriage          |
| <input type="checkbox"/> Stomach aches      | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Speech/language problems       |
| <input type="checkbox"/> Abortion           | <input type="checkbox"/> Chronic pain        | <input type="checkbox"/> A sexually transmitted disease |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Thyroid problems               |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Other _____         | <input type="checkbox"/> Other                          |

List any major health problems for which you currently receive treatment \_\_\_\_\_

List any medications you are now taking \_\_\_\_\_

Please continue next page

Please rate the importance of the following concerns as they may apply to you. If the issue is not a problem for you, please leave it blank.

Mild = 1      Moderate = 2      Serious = 3      Severe = 4      Extreme = 5

- |   |                                      |                                      |
|---|--------------------------------------|--------------------------------------|
| ___ Marital stress                      | ___ Feeling worthless                | ___ Upset stomach                    |
| ___ Other family problems               | ___ Drawing away from people         | ___ Sweating                         |
| ___ Other relationship problems         | ___ Lack of interest/enjoyment       | ___ Lightheaded/dizzy                |
| ___ Problems at work/school             | ___ Too many drugs                   | ___ Too much worry                   |
| ___ Health problems                     | ___ Too much alcohol                 | ___ Too many fears                   |
| ___ Financial problems                  | ___ Feel negative about future       | ___ Feeling guilty                   |
| ___ Legal problems                      | ___ Hard to make friends             | ___ Feeling angry/frustrated         |
| ___ Sad/depressed                       | ___ Feeling lonely                   | ___ Nightmares                       |
| ___ Loss of appetite                    | ___ Sexual problems                  | ___ Feel ignored/abandoned           |
| ___ Loss of weight                      | ___ Less energy than usual           | ___ Too much pain                    |
| ___ Gain of weight                      | ___ More energy than usual           | ___ Confused                         |
| ___ Difficulty sleeping                 | ___ Very talkative                   | ___ Laugh without reason             |
| ___ Difficulty concentrating            | ___ Restless/can't sit still         | ___ Memory problems                  |
| ___ Quick change of moods               | ___ Nervous/tense                    | ___ See/hear strange things          |
| ___ Dwelling on problems                | ___ Panicky                          | ___ Feel used by people              |
| ___ Problems with breathing             | ___ Shaky/trembling                  | ___ Feeling others are out to get me |
| ___ Hot or cold spells                  | ___ Hard to trust anyone             | ___ Watched/talked about by others   |
| ___ Feeling suicidal                    | ___ Coping with divorce              | ___ Cry without reason               |
| ___ Problems controlling anger or urges | ___ Problems controlling my thoughts |                                      |

Questions – please answer with a yes or no

Circle One

- |  |   |   |
|--|---|---|
| 1. Have you ever felt you ought to cut down on your drinking?            | Y | N |
| 2. Have people annoyed you by criticizing your drinking?                 | Y | N |
| 3. Have you felt bad or guilty about your drinking?                      | Y | N |
| 4. Have you ever had an eye-opener to steady your nerves in the morning? | Y | N |

