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 _____

Your Employer _____

Occupation _____

Briefly describe your reason for seeking help _____

_____

_____

_____

_____

Who suggested you contact us? _____ _____

When were you last examined by a Physician? _____ _____

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 issues 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

____ Other -- Please describe _____

_____