

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

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|---|--------------------------------------|---|
| ___ 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 _____ | | |
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