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?

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