

**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<br>get me |
| ___ Hot or cold spells                  | ___ Hard to trust anyone             | ___ Watched/talked about by<br>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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