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 ____

____

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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