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CLIENT QUESTIONNAIRE

What is the problem or concern that led you to seek therapy? How long has this been a problem or concern?

What are you expecting from counseling?

Have you sought counseling in the past to address the concerns that brought you here? If so, who did you see and when? Was the counseling helpful or not and why?

CHECK ANY OF THE FOLLOWING THAT OFTEN APPLY TO YOU

☐ Loss of Control ☐ Temper Outbursts ☐ Procrastination ☐ Cry Often
☐ Sleep Disturbances ☐ Eating Problems ☐ Work Too Much ☐ Can't Keep a Job
☐ Repetitive Thoughts ☐ Suicidal Thoughts ☐ Suicidal Attempts ☐ Risky Behavior
☐ Use Drugs/Alcohol/Tobacco ☐ Bullying Behavior ☐ Physically or Verbally Aggressive

☐ **Trauma – Circle all that apply and indicate if C - (child) or A - (adult)**
Physical Violence _____ Sexual Abuse _____ Domestic Violence _____ Combat _____ Auto Accident _____
Other _____

MEDICAL QUESTIONNAIRE

Who is your Primary Care Physician? _____ Okay to Contact? ☐ No ☐ Yes

Date of last physical Exam _____ Rate present physical health ☐ Good ☐ Fair ☐ Poor

Do you experience pain ☐ No ☐ Yes Are you currently treated? ☐ No ☐Yes If yes by whom? _____

Allergies? _____

Medication	Frequency	Prescribed by	Length of Use

CHECK ANY OF THE FOLLOWING MEDICAL ISSUES THAT APPLY TO YOU

☐ Diabetes ☐ High Blood Pressure ☐ Seizures ☐ Heart Problems ☐ Asthma ☐ Kidneys
☐ Head Injury ☐ Weight Management ☐ Arthritis ☐ Muscle/Joint Pain ☐ Headaches ☐ Stomach Problems
☐ Fatigue ☐ Sexual Disturbances ☐ Numbness ☐ Immune System ☐ Memory Difficulties

Other: _____

_____

☐ Major Operations? If yes please explain _____

☐ Hospitalizations? If yes please explain _____

I certify the information provided is true and up to date:

_____ _____
Client Signature Date