CLIENT INFORMATION

The purpose of this questionnaire is to get a picture of your personal, family and marital background. Please answer the questions as accurately as you can and feel free to ask questions regarding the questionnaire at any time.

Date:_____

NAME:_____ AGE:_____

ADDRESS:_____ DATE OF BIRTH:_____

_____ _____

Children: (Please check one) YES_____ NO_____

(If yes) NAMES_____ AGES:_____

_____ _____

Live with you: FULL TIME_____ PART TIME_____

PHONE NUMBERS: HOME_____ WORK_____ CELL _____

Can I call you at Home:Yes_____No_____ Work:Yes_____No_____ Cell: Yes____No ____

PLACE OF WORK:_____ Profession: _____

Email Address: _____

Can I email you at this address? Yes_____No _____

WHO REFERRED YOU? AGENCY:

RELATIONSHIP STATUS: I am: in relationship ____ married _____ living with partner _____
not in relationship_____ in polyamorous relationship(s)

Number of years in relationship to current partner(s) _____

FAMILY OF ORIGIN INFORMATION

Mother's Name _____ Age_____ Living or deceased _____

Health_____Profession _____

Father's Name _____ Age_____ Living or deceased _____

Health_____Profession _____

Write 3 positive adjectives to describe your Mother:

1. _____
2. _____
3. _____

Write 3 negative adjectives to describe your Mother:

_____
_____
_____

Write 3 positive adjectives to describe your Father:

1. _____
2. _____
3. _____

Write 3 negative adjectives to describe your Father:

_____
_____
_____

CURRENT PROBLEM/ISSUES – describe

_____

_

_____

_

_____

HEALTH

1. Are you on any medication: (Please check one) YES_____ NO_____

IF YES, Please list NAMES OF MEDICATION, DOSAGE AND FREQUENCY TAKEN:

_____

2.When was your last check up?_____ Physician's Name_____

Physician Phone Number_____

3.HAVE YOU EVER GIVEN SERIOUS CONSIDERATION TO, OR ATTEMPTED TO, END YOUR OWN LIFE?

YES_____NO_____

IF YES, please describe:_____

_____

4. In case of emergency please contact:

NAME:_____

PHONE:_____

5. IS THERE A HISTORY IN YOUR FAMILY OF ANY OF THE FOLLOWING (Please check all that apply):

	YOU	PARTNER	CHILD(REN)	BRIEF EXPLANATION
ANXIETY				
DEPRESSION				
ALCOHOLISM/DRUGS				
ANGER				
WORKAHOLISM				
EATING DISORDER				
FOOD ADDICTION				
SPENDING/GAMBLING				
SEX ADDICTION				
SEXUAL ABUSE				
RAPE_				
PHYSICAL ABUSE				
EMOTIONAL ABUSE				
VIOLENCE				
SLEEP DISORDERS				
PHYSICAL CONDITIONS				

6. Check all of the following areas which have been or are a problem for you? (Please check one for each area):

Marriage/partner	YES___NO___	Family	YES___NO___
Job/School	YES___NO___	Health	YES___NO___
Finances	YES___NO___	Legal	YES___NO___
Friendships	YES___NO___	Mood	YES___NO___
Anxiety Level	YES___NO___	Eating habits	YES___NO___
Spirituality	YES___NO___	Anger	YES___NO___
Alcohol	YES___NO___	Drugs	YES___NO___
Sexual Difficulties	YES___NO___	Caffeine	YES___NO___
Ability to control your temper	YES___NO___	Smoking	YES___NO___

Other areas not listed:_____

7. ADDITIONAL INFORMATION: Anything else you think I should know?

Thank you for taking the time to fill out this questionnaire