CLIENT INFORMATION QUESTIONNAIRE
All Information Confidential

General Information Date ________________________________

Print Name_____________________________________ Age _____ Sex _____ DOB ______________

Emergency Contact Name__________________Phone #______________Relationship______________

(Who may we contact in case of an Emergency)

Current Family Doctor/Practice____

Other Therapist/Doctors____

Pharmacy
Name/Location/Phone____

Do you have a WRAP plan? _________ Yes _________ No

Do you have Advanced Directives? _________ Yes __________ No

1. To help us understand better what concerns you may have, please circle any of the following problems which pertain to you:

Nervousness	Anger	Loneliness
Depression	Self-Control	Inferiority Feelings
Fears	Unhappiness	Concentration
Shyness	Sleep	Education
Sexual Problems	Stress	Career Choices
Suicidal Thoughts	Work	Health Problems
Separation	Being a Parent	Temper
Divorce	Headaches	Nightmares
Finances	Tiredness	Marriage
Drug Use	Legal Matters	Children
Alcohol Use	Energy	Appetite
My Thoughts	Making Decisions	Stomach Trouble

2. Have you ever received mental health or substance abuse treatment? _______No _______ Yes
_____ Inpatient _____ Outpatient
Place/Provider ____________________ Year(s) __________ Reason ____________________________
Place/Provider ____________________ Year(s) __________ Reason ____________________________
Place/Provider ____________________ Year(s) __________ Reason ____________________________
Place/Provider ____________________ Year(s) __________ Reason ____________________________
Place/Provider ____________________ Year(s) __________ Reason ____________________________

3. When were you last seen by a mental health professional? ____ Not applicable
____

4. Do you drink alcohol? _______No _______ Yes
Type ________________________ Amount ____________________________ Last Drink _____________

5. Have you ever had a problem with alcohol? _______No _______ Yes
Describe
____

6. Have you ever had a problem with substance abuse (other than alcohol)? _______No _______ Yes
Describe
____

7. Do you use tobacco in any form?
_______No _______ Yes Describe
____

8. Current caffeine consumption (Soda, Coffee, Tea, Iced Tea, etc.)? _______No _______ Yes
Amount ____

9. Do you take medications? Please include Over the Counter (OTC) medications, herbal preparations, dietary supplements, etc.? _______No _______ Yes

Drug	Dose	Frequency	Reason	Who Prescribed

10. Do you have any health problems? _______No _______ Yes

Please list:

____

____

11. Have you had any major, non-psychiatric hospitalization? _______No _______ Yes

<u>Place</u> <u>Year</u> <u>Reason</u>

____

____

____

____

____

12. Height ____________________________ Weight ______________________________________

13. Have you any drug allergies or sensitivities? _______No _______ Yes

Please list:

<u>Drug</u> <u>Symptom</u>

____

____

____

____

14. Have you any other allergies or sensitivities (e.g. environmental, food, dye, latex, etc.)

_______No _______ Yes

Describe ____

____

15. In the past, have you ever been on medication for anxiety, depression, insomnia, etc.?

_______No _______ Yes

If yes,

Drug When How Long Effectiveness Side Effects Why Discontinued

___

___

___

___

___

16. Do you have any family history of mental illness or substance abuse? _______No _______ Yes

Describe___

___

___

To assist in completing a comprehensive assessment, we are required to ask the following questions regarding cultural/spiritual issues.

17. With what ethnic/cultural/racial group do you identify?

___

18. What is your religious affiliation?

___

19. What role does your religion/spirituality play in your life?

___ Positive ___ Negative ___Neutral

20. Are there any spiritual or cultural issues that you feel need to be taken into account in your treatment? __ Yes __ No If yes, please identify?

___

___

For statistical/funding purposes, please complete the following questions:

Ethnicity ___

Income ___

Supporting how many ___

Client's Signature ___