New Client Questionnaire

Thank you for taking a few minutes to fill out this form. The information you provide is confidential*, and will be helpful for when you and I meet for the first time.

Today's Date _____

Name _____

Age _____ Date of Birth _____/_____/____ Gender: □ Male □ Female

Address _____

City_____ State_____ ZIP_____

Phone Number: (Primary) _____ May I leave a message? □ Yes □ No

Phone Number: (Secondary)_____May I leave a message? □ Yes □ No

Email _____ May I email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Ethnicity_____ Education _____

Emergency contact (name, relationship, phone number):

_____

Relationship Information:

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

On a scale of 1-10, how would you rate your relationship? _____

Spouse's Name (if applicable) _____ Age _____
Spouse's Occupation (if applicable) _____

Please list any children/ages: _____

Do your children live with you? Y____ N____ Not Applicable____

I would describe my friendships as:

Close ___ Somewhat close____ Distant____ Conflicted____

I would describe my relationship with my mother as:

Close ___ Somewhat close____ Distant____ Conflicted____

I would describe my relationship with my father as:

Close ___ Somewhat close____ Distant____ Conflicted____

How many siblings do you have? _____

How would you describe your relationship with your siblings? _____

Please describe your current living arrangements (Do you live with others?)

_____

Medical Information:

Doctor's name and phone number: _____

Are you currently taking any prescription medication? □ Yes □ No

If yes, please list: _____

_____

Please list any specific health problems you are currently experiencing:

_____

Mental Health History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner: _____

Are you currently seeing a psychiatrist or therapist? □ Yes □ No

Have you or a family member ever been hospitalized for mental or emotional illness? □ Yes □ No

If yes, please explain—reason for hospitalization, dates?

_____

Have you been hospitalized for suicidal thoughts or actions? □ Yes □ No

If yes, please describe _____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates: _____

Do you have a substance abuse or addiction history? □ Yes □ No

If yes, please describe: _____

Have you ever been arrested or imprisoned for violent behavior or threats? □ Yes □ No

If yes, please describe: _____

Legal History (arrests, prison, DWI?):_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, etc.).

Suicide Attempts	□ Yes □ No	Family member:
Anxiety	□ Yes □ No	Family member:
Depression	□ Yes □ No	Family member:
Domestic Violence	□ Yes □ No	Family member:
Eating Disorder	□ Yes □ No	Family member:
Alcohol/ Substance Abuse	□ Yes □ No	Family member:
Compulsive Behavior	□ Yes □ No	Family member:
Schizophrenia	□ Yes □ No	Family member:

Additional Information:

Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be spiritual or religious? □ Yes □ No

If yes, describe your faith or belief:

_____

Who referred you to me? _____

How can I help?

Please tell me in your own words what brings you here today:

_____

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

_____

What significant life changes or stressful events have you experienced recently:

_____

_____

_____

Are you having any current suicidal thoughts or feelings? □ Yes □ No

If yes, please describe: _____

Are you having any current homicidal or violent thoughts? □ Yes □ No

If yes, please describe: _____

Are you currently experiencing overwhelming sadness, grief, or depression? □ Yes □ No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ Yes □ No

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? □ Yes □ No

If yes, please describe: _____

Any current threats of significant loss (illness, divorce, custody, job loss, etc.)? □ Yes □ No

If yes, please describe: _____

_____

THANK YOU for taking the time to fill out this information sheet. This will be reviewed with you during your first counseling session.

* All communications and records with Lisa Constance, LLPC are held in strict confidence. Information may be released, in accordance with state law, when (1) the client signs a written release indicating consent to release; (2) the client expresses serious intent to harm self or someone else; (3) there is reasonable suspicion of abuse against a minor, elderly person, or dependent adult; (4) to acquire payment for services or for billing purposes; or (5) a subpoena or court order is received directing the disclosure of information.