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Thank you in advance for your time in completing this confidential questionnaire. The information will help me understand your situation. When added to our meetings together, it will help us find an effective approach to the challenges we shall be considering together. Your replies will be held in confidence as required by law.

Please add any information that you believe might be relevant, using the reverse sides of pages if necessary.

Name _____ Age_____ Date of Birth_____

Address _____ City_____

Zip_____

Phone numbers: Home _____ Work_____

Do you authorize permission to call home phone number? Yes_____ No_____

Do you authorize permission to call work phone number? Yes_____ No_____

May I leave a message? Yes_____ No_____

If not, please specify which numbers_____

Occupation _____

Referred by: _____

PLEASE FILL IN THIS SECTION IF CLIENT IS UNDER 18 YEARS OF AGE

Parent/Guardian: _____ Phone _____

Address _____ City_____

Zip_____ Employer _____Phone _____

In case of an Emergency, I should contact:

Name _____ Phone_____

Relation_____

Address _____

City_____Zip_____

FAMILY INFORMATION

While it is impossible to create a form that will describe every family, I hope to better understand your situation through the completion of your family information. Feel free to add explanations or other information that you think would help provide an accurate picture of your family.

Spouse(s): Name Age Years married/Year divorced Current City/State of residence

1._____

2._____

3._____

4._____

PARENTS:

Mother's name: _____ Age: _____

Living? Yes ___ No ___ Occupation (current or prior): _____

Cause of death, if deceased:_____ If living, where?: _____

Married to other parent?: Yes ___ No ___ Remarried: Yes ___ No ___

Father's name: _____ Age: _____

Living? Yes ___ No ___ Occupation (current or prior): _____

Cause of death, if deceased:_____ If living, where?: _____

Married to other parent?: Yes ___ No ___ Remarried: Yes ___ No ___

Sibling(s): Name Age Current City/State of residence

1._____

2._____

3._____

4._____

Other significant family members, family you are especially close to, live or lived with:

1._____

2._____

3._____

4._____

Have any family members had problems:

With alcohol? Yes ___ No ___ How related? _____

With drugs? Yes ___ No ___ How related? _____

With their mental health? Yes ___ No ___ How related? _____

Attempted or committed suicide? Yes ___ No ___ How related? _____

School Information

School Attending_____Grade_____

Any special programs (SLD, Speech, Gifted, EH, etc.)?_____

Was your child evaluated by a school psychologist?_____ if so, when?_____

Are there any behavior concerns at school (suspensions, expulsions, office referrals, etc.)

_____

Special activities enjoyed at school_____

_____

Interests outside of school_____

_____

Developmental and Medical Information

Anything unusual about your child's birth (low birth weight, long labor, fetal distress, etc.)_____

_____

Were there any difficulties with your child meeting developmental milestones (sitting up, crawling, walking, talking, etc.)?_____

_____

Difficulties toilet training?_____

_____

Is your child now experiencing any toileting difficulties (bed wetting, bowel control, etc.)?_____

_____

Is your child sensitive to touch, taste, sounds, or light?_____

Describe your child's current physical health:

Excellent____ Good_____ Fair_____ Poor_____

Physician's name:_____

Physician's address:_____

Physician's phone number:_____

Is your child currently being treated for any medical condition? Please describe.

_____

_____

Does your child currently take any medication? If so, please list.

_____

_____

Has your child had any surgeries? Please describe.

_____

_____

Has your child had any accidents or traumatic physical events (broken bones, car accidents, severe lacerations, head injury, sutures, etc.)?

_____

_____

Has your child witnessed any traumatic events (other people being injured, etc)?

_____

_____

Does your child have any known history of sexual, physical or emotional abuse?

_____

_____

Family and Social Information

Was your child adopted? If so, at what age and from what country?

Do you have concerns that your child may be abusing alcohol or drugs or engaging in any other illegal activities?

_____

_____

Has your child seen a counselor or therapist before?

_____

_____

Is there a family history of mental health concerns (depression, anxiety, bi-polar, etc.?)

_____

_____

CONSENT TO TREATMENT

I consent to a psychotherapeutic evaluation and treatment. I have received a client handbook and agree with the terms stated therein.

_____ _____

Signature of Child or Adolescent **Date**

_____ _____

Signature of Parent or Legal Guardian **Date**

CONFIDENTIAL CLIENT QUESTIONNAIRE

Name _____ DOB _____

Briefly describe your reasons for seeking help at this time:

_____

_____

_____

_____

_____

_____

Please circle any concerns which pertain to you:

Nervousness	Depression	Fears
Sleeping	Sexual Problems	Suicide Thoughts
Eating Problem	Alcohol-Drug Use	Friends
Finances	Stress	Employment Issue
Legal Matters	Memory/Concentration	Perfectionism
Self-Control	Inferiority Feelings	Unclear Self-Image
Self-Confidence	Career Choices	Health Problems
Anger	Nightmares	Marriage
Children	Parents	Sexual Orientation
Guilt	Making Decisions	Thoughts
Fearing Failure	Feeling Empty	Anxiety
Breakup of Relationship	Feeling Worthless	Self-Esteem
Communication	Hopelessness	Panic
Obsession/Compulsion	Hearing Voices	Weight
Relationship Issues	Seeing Strange Things	Body Image
Spirituality	Resentment	Grief and Loss

PERSONAL HISTORY

Which stresses have you over come in the past? _____

_____

_____

How did you do it?_____

_____

_____

What are your personal strengths? _____

_____

_____

What are your hobbies? _____

_____

_____

Do you practice a religion? Yes ___ No ___ If so, what? _____

If yes, describe your involvement with your religion_____

If not, do you believe in God? Yes ___ No ___

Did you graduate from high school? Yes ___ No ___ Where? _____

Have you had any history of difficulties at school? Yes ___ No ___

If yes, please describe: _____