Psychotherapy and Counseling Division

Client Questionnaire

Name: ____ Date: __________________________

Please state briefly why you are seeking counseling services.____

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How would you assess the severity of these concerns? ( ) Mild ( ) Moderate ( ) Severe

Have you recently experienced the following?
Please check using number rating scales
1 = mild 2 = moderate 3 = severe
NA = Not Applicable

	NA	1	2	3
Anxiety				
Panic Attacks				
Depression				
Suicidal Thoughts				
Homicidal Thoughts				
Anger				
Fear				
Unwanted Thoughts				
Dizziness				
Blurred Vision				
Stomach Pains				
Back Aches				
Chest Pains				
Headaches				
Change in Weight				
Eating Problems				
Sleeping Difficulties				
-Falling Asleep				
-Staying Awake				
-Waking Early				
Learning Difficulties				
Menopausal Symptoms				

Have you or family members experienced the following? Please check those applicable.

	You	Family	NA
Heart Attack			
Stroke			
High blood pressure			
Diabetes			
Cancer			
Epilepsy			
Thyroid problems			
Hypoglycemia			
Multiple sclerosis			
PMS			
Hospitalizations			
Alcoholism/Drug Abuse			
Drug Addiction			
Problem Gambling			
Mental illness			
Suicide			
Sexual abuse			
Emotional/Physical Abuse			
Family Violence			
Death of Someone Close			
Allergies			
Specify:			
Physical Disability			

Please list any prescription or non-prescription medications you are presently taking.

Medication	**Dosage**	**Purpose**
______________________	________________	______________________
______________________	________________	______________________
______________________	________________	______________________

Date of last medical exam? ________ Doctor Name: _________________ What was the reason?________________________
Recent hospitalization and reason? ____
Do you smoke? __________ If so, how much? ____
How many caffeinated beverages (coffee, tea and soda pop) do you drink each day? _____________________________
What is your alcohol and/or drug consumption? ____
Has it changed recently? (If yes, Please explain) ____