CSK MFT

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CLIENT QUESTIONNAIRE

To help me become familiar with you and your concerns, would you please take a few minutes to complete this form. If you do not feel comfortable answering specific questions, you may skip them and discuss them with me in person.

GENERAL INFORMATION

Name_____ Today's Date _____

Your Address _____
street city zip

Phone Numbers _____
home work cell

Which number do you prefer that I use first when attempting to contact you? _____

At which number(s) may I leave a message for you? _____

Email _____

Date of Birth:_____Age_____ Marital/Relationship Status _____

Referred by_____
name relationship

May I thank them for the referral? ❑ Yes ❑ No

Education Level_____Occupation _____

Who lives with you? _____

Emergency Contact Information

_____
name phone relationship to you

_____
name phone relationship to you

FINANCIAL INFORMATION

How do you intend to pay for treatment? ❑ Cash ❑ Check ❑ Credit Card

Are you interested in attaining insurance reimbursement? ❑ Yes ❑ No

FAMILY OF ORIGIN BACKGROUND

Your Mother's Name_____ Living? ❑ Yes ❑ No

Briefly describe your relationship with your mother_____

_____

Your Father's Name _____ Living? ❑ Yes ❑ No

Briefly describe your relationship with your mother_____

_____

Names and ages of your siblings_____

_____

Names and ages of your children _____

_____

PROBLEMS/CHALLENGES

Please mark any of the following problems that you are currently experiencing.

❑ Depression
❑ Suicidal thoughts
❑ Suicidal actions
❑ Anxiety/fear/worry
❑ Anger/temper issues
❑ Alcohol/other drug abuse (self)
❑ Job/school problems
❑ Financial concerns
❑ Legal problems
❑ Death of a loved one
❑ Major losses/changes in life
❑ Parent-child conflict (self)
❑ Parent-child conflict (spouse/partner)
❑ Marital/relationship problems
❑ Sibling problems
❑ Family violence (actual or threatened)
❑ Communication problems
❑ Sexual problems
❑ Sexual abuse (current or past)
❑ Physical abuse (current or past)
❑ Gambling issues
❑ Eating/food/body image issues
❑ Other (please specify)_____

_____

HOW WELL ARE YOU COPING?

Please mark any of the following problems that you are currently experiencing.

❑ Sleeping problems
❑ Difficulty falling asleep
❑ Waking up at night
❑ Sleeping too much
❑ Nightmares
❑ Moodiness/crying more than usual
❑ Feeling guilty, worthless or hopeless
❑ Fatigue/low energy
❑ Hyper/too much energy
❑ Loss of interest/low motivation
❑ Disturbing thoughts I can't stop
❑ People are out to get me
❑ Change in appetite ❑ more? ❑ less?
❑ Gaining weight (how much? _____)
❑ Losing weight (how much? _____)
❑ Nauseated
❑ Constipation
❑ Diarrhea
❑ Difficulty concentrating
❑ Problems remembering things
❑ Withdrawing from others
❑ Repeated actions I can't stop (washing hands, checking locks, etc.)
❑ People are picking on me
❑ Other (please specify)_____

_____

RELATIONSHIP EXPERIENCES

Please mark any that currently apply to you.

- ❑ I don't have enough friends
- ❑ I have enough friends
- ❑ I talk to my friends about problems
- ❑ I don't talk to my friends about problems
- ❑ I consider myself to be shy
- ❑ I find it hard to keep friends
- ❑ I make friends easily
- ❑ I find it hard to open up to others
- ❑ Other people pick on me
- ❑ Few people seem to understand me

YOUR SOURCES OF STRESS

Please list the 3 most common sources of stress in your life:

1) _____

2) _____

3) _____

HOW DO YOU COPE WITH STRESS?

Please list the 3 coping strategies you use most often (sleep, yoga, exercise, etc.):

1) _____

2) _____

3) _____

YOUR LIFESTYLE

Do you smoke? ❑ Yes ❑ No Packs per day? _____

Do you drink alcohol? ❑ Yes ❑ No Drinks per day?_____

Do you use other drugs? ❑ Yes ❑ No If "yes," which ones?_____

How much do you take at once? _____

How often do you use drugs?_____

Have you ever been treated for substance abuse? ❑ Yes ❑ No

Do you use caffeine products? ❑ Yes ❑ No How much per day? _____

Have you ever had legal charges brought against you? ❑ Yes ❑ No If "yes," please specify what kind of charges and when they were issued_____

_____

Are there any guns or weapons in your home? ❑ Yes ❑ No

CURRENT FUNCTIONING

Using the following scale, please circle the number that most accurately indicates your current level of functioning. "0" is lowest (not coping at all), while "10" means that you are coping with things better than you ever have.

◄ ---------- ►

0 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Please mark any of the following problems that you are currently experiencing or have experienced in the past.

❑ Asthma	❑ Diabetes	❑ Ulcers	❑ Migraines
❑ Epilepsy	❑ Seizures	❑ Lupus	❑ Stroke
❑ Cancer	❑ Heart Condition	❑ Multiple Sclerosis	❑ Headaches
❑ Previous Head Injury	❑ Thyroid	❑ Gynecological Problems	❑ Drug Allergies

If you answered "yes" to any of the above, please briefly explain: _____

_____

_____

Have you ever been diagnosed or treated for Major Depression? ❑ Yes ❑ No _____

Have you ever been diagnosed or treated for Bipolar Disorder? ❑ Yes ❑ No _____

Have you ever been diagnosed or treated for Schizophrenia? ❑ Yes ❑ No _____

Previous Hospitalizations: (please list date and reasons) _____

_____

Previous Suicide Attempts (please list dates and methods) _____

_____

_____

Current Medications (prescriptions, over-the-counter and vitamin/herbal supplements) _____

_____

Family Medical History (list any major family medical problems, alcohol or drug use) _____

_____

_____

Has any family member been treated for Schizophrenia? ❑ Yes ❑ No

Has a family member been treated for Manic-Depressive Disorder? ❑ Yes ❑ No

Has a family member been treated for Major Depression? ❑ Yes ❑ No

Has a family member been treated for Substance Abuse? ❑ Yes ❑ No

If "yes," please specify who and when _____

_____

_____

PREVIOUS COUNSELING EXPERIENCES

Have you ever been in counseling/therapy before? ❑ Yes ❑ No

If "yes," please explain what dates you were in therapy, the reason(s) for counseling and the reason(s) why counseling was completed.

_____

_____

_____

_____

What did you like most about counseling/therapy?_____

_____

What did you like least about counseling/therapy? _____

_____

YOUR GOALS

Please list up to 5 goals that you hope to accomplish in counseling.

1) _____

2) _____

3) _____

4) _____

5) _____

YOUR CONSENT TO PARTICIPATE IN THERAPY

_____

SIGNATURE DATE

_____

PARENT/GUARDIAN SIGNATURE (if under age 18) DATE