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NEW CLIENT QUESTIONNAIRE

**If you run out of space when answering any questions, please use the back of this sheet or add a new sheet.*

DATE: _____

NAME:_____ DOB: _____

Please describe your main complaints that brought you here.

_____

_____

_____

_____

Please describe goals that you would like to achieve through therapy/assessment.

_____

_____

_____

_____

EDUCATIONAL/MILITARY BACKGROUND

Do you have any knowledge of your mother having complications or difficulties during pregnancy?

□ Yes □ No (If yes, explain.) _____

Any drugs or alcohol consumed pregnancy? □ Yes □ No

Did you reach developmental milestones (e.g., rolling, walking, talking) age-appropriately? □ Yes □ No

Did you have any issues as a child in any of these areas below?

□ speech/language □ motor skills □ cognitive/intellectual □ sensory □ behavioral □ emotional □ social

(If yes, explain.) _____

_____

What is the highest school degree you have earned? _____

Are you in school now (If yes, provide detail)? □ Yes □ No _____

_____

During school, did you receive any: □ special education □ diagnosis of learning disabilities □ diagnosis of ADHD □ tutoring □ alternative schooling □ disciplinary actions

Have you ever serviced in the military? □ Yes □ No (If yes, please specify.)

Date of services: _____ Type of discharge: _____

Combat experiences? _____ Highest rank: _____

MENTAL HEALTH HISTORY

1. Have you received any mental health services, including psychological assessment prior to coming here? Please mark all that apply.

□ None □ Partial care □ Other 24-hour care □ Substance abuse rehab/detox center

□ outpatient therapy □ inpatient care □ psychological assessment

If yes, please list the name(s) of facility or treatment/service provider, the date/duration of service, and the purpose of service.

_____

_____

_____

_____

_____

2. Have you been diagnosed with any psychiatric disorders? □ Yes □ No

If yes, please specify: _____

_____

3. Have you been on any psychotropic medications? □ Yes □ No

If yes, please specify: _____

_____

4. Are you currently on any psychotropic medications? □ Yes □ No

If yes, please specify (Name, dosage, and reason for taking):

_____

_____

_____

_____

Who is currently monitoring your psychotropic medications? _____

6. Current physician/psychiatrist (Name, contact number)

_____

_____

May I contact your physician/psychiatrist? □ Yes □ No
(If yes, I'll ask you to fill out the form of authorization to release information later.)

7. Have you experienced any of the following problems within the recent month period? (Please mark all that apply): □ depression □ extreme mood swings □ social isolation □ no/little appetite □ significant weight change □ difficulty concentrating □ overeating □ always tired □ sleep problems □ nightmares □ anger/hostility □ suicidal thoughts □ anxiety □ feeling panicky □ obsessions □ gambling □ feeling tense □ worried excessively □ job problems □ financial problems □ relational problems □ family conflicts □ unusual thoughts or beliefs □ overwhelming crisis □ self-inflicted injury or pain □ feeling people are out to get me □ hearing or seeing things that other people don't □ low self-esteem

8. Have you recently used alcohol or illicit drugs (□ marijuana, □ methamphetamines, □ cocaine, □ party drugs, □ LSD □ heroine, or □ hallucinogens), or □ misused prescribed medications

If yes, please elaborate the average amount at a time, and the frequency per week:

_____

_____

_____

_____

9. Have you ever tried to cut down on your use of alcohol or drugs? □ Yes □ No

10. Has anyone gotten angry at you or expressed serious concerns about you because of your alcohol or drug use? □ Yes □ No

11. Have your ever felt guilty or worried about your use of alcohol or drugs? □ Yes □ No

12. Have you experienced significant life changes or stressful events recently?

If yes, please explain: _____

_____

13. Do you have any history of □ criminal activities/incarceration (If yes, mark all that apply:

□ arrest/ assault □ arrest/other* □ DUI □ restraining/protective order(s) □ child protective services

□ divorce/custody □ disability claim(s) □ other: _____)

□ aggression/violence □ domestic violence □ alcohol or drug abuse □ gambling □ self-injurious behavior

□ child abuse (If yes, mark all that apply: □ physical □ emotional □ verbal □ sexual

□ neglect □ abandonment; by who?_____

When?_____)

□ suicidal attempt (If yes, how many times? _____ when? _____,

what methods? _____)

14. Are you currently involved in legal proceedings? □ Yes □ No

If yes, explain: _____

_____

15. Who do you live with? (Ages and relationships to you)

_____

_____

16. Any familial history of mental illness? (Who and what diagnosis?)

_____

_____

MEDICAL HISTORY

1. Have you seen a physical or other health care professional within the last six months for reasons other than a physical checkup? □ Yes □ No

If yes, please specify reason(s): _____

_____

2. Please mark any of the following that you have experienced:

□ headaches □ dizziness □ fainting spells/blackouts □ severe or prolonged nausea

□ seizures or convulsions □ memory loss □ allergies □ asthma □ ulcers □ high blood pressure

□ chronic pain □ nerve pain □ arthritis □ diabetes □ hypoglycemia (low blood pressure)

□ heart disease □ gastrointestinal issues □ traumatic head injury (if yes, when? _____

concussion? □ Yes □ No Unconsciousness? □ Yes □ No Hospitalized? □ Yes □ No)

□ any other medical conditions (specify:_____)

3. Please list a history of major illnesses, traumatic brain injury, surgeries, and/or serious injuries with dates of the applicable incident(s): _____

_____

_____

_____

Thank you for completing this form!