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NEW CLIENT QUESTIONNAIRE

Today's Date: _____

PERSONAL INFORMATION

First Name: _____ Last Name: _____

Preferred Name: _____ Age: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ *May I call this number?* Y N *May I leave a message?* Y N

Cell Phone: _____ *May I call this number?* Y N *May I leave a message?* Y N

Email Address: _____

Is it okay to email you at this address regarding scheduling and/or administrative issues? Y N

Person responsible for bill: _____ Relationship to you: _____

Address: _____ Phone: _____

INSURANCE INFORMATION

Primary Coverage

Name of Insured: _____ DOB of Primary Insurance Holder: _____

Insurance Company: _____

Address: _____ Phone: _____

Subscriber/ID #: _____ Group #: _____

Secondary Coverage

Name of Insured: _____ DOB of Primary Insurance Holder: _____

Insurance Company: _____

Address: _____ Phone: _____

Subscriber/ID #: _____ Group #: _____

REFERRAL INFORMATION

Who referred you? _____ Relationship: _____

Other (e.g., internet search, Psychology Today, word of mouth etc.): _____

EMERGENCY CONTACT

Emergency Contact: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Your responses to the following sections will help us to maximize our time together during our first session. However, if there are any questions that you feel uncomfortable answering, you may leave them blank and we will discuss them at our initial appointment.

EMPLOYMENT INFORMATION

Are you currently employed? Yes No (If no, please skip to the next section)

Employer: _____ Occupation: _____

Address: _____

Approximately how many hours per week do you work? _____

Please briefly describe the environment of the setting you work in (e.g., indoor office, outdoors, itinerant):

_____

ACADEMIC INFORMATION

Are you currently a student? Yes No (If no, please skip to the next section)

What school/university/college do you attend? _____

What year are you currently enrolled in?

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate Student

What is your academic major or specialization? _____

DEMOGRAPHIC INFORMATION

Please describe yourself as fully as you feel comfortable.

1. What is your gender? _____ **What pronouns do you use?** _____

2. Preferred Language: _____

3. Racial/Ethnic Background: What race(s) and/or ethnicity(ies) do you consider yourself?

_____

4. What is your sexual orientation? _____

5. Relationship Status:

- ☐ Single
- ☐ Partnered
- ☐ Poly/Open/Non-monogamous
- ☐ Engaged
- ☐ Married
- ☐ Separated
- ☐ Remarried
- ☐ Divorced
- ☐ Widowed

6. Religious Affiliation/Spirituality: What is your religious or spiritual preference? _____

How important of a role does your religious or spiritual preference play in your life?

☐ Very Important ☐ Important ☐ Neutral ☐ Unimportant ☐ Very Unimportant

7. Disability Status: Do you identify as having a disability? YES NO

If yes, please specify: _____

8. Military Service: Have you ever been, or are you currently, enlisted in any branch of the U.S. Military?

YES NO

If yes, please specify: _____

Did your military experiences include any traumatic or highly stressful experiences that continue to impact you?

YES NO

CURRENT & PREVIOUS COUNSELING/THERAPY EXPERIENCES

If you have previously sought counseling or therapy for mental health concerns, please specify the date(s) and the reason for seeking services: _____

_____

_____

Name of current mental health provider (if any): _____

Contact Information: _____

If you currently or have previously been prescribed medication for mental health concerns, please specify here:

Name of Psychotropic Medication	Dates Taken	Dose/Times per Day	Condition(s) being Treated	Name of Prescribing Professional

MEDICAL & HEALTH INFORMATION

Physician: _____ Phone: _____

1. Please list any other current medications in the table below:

Name of Medication	Date Started Taking	Dose/Times per Day	Condition(s) being Treated	Name of Prescribing Professional

2. If you have any serious medical conditions, please describe: _____

_____

3. Caffeine & Substance Use — *Please describe your average weekly frequency and amount used:*

Alcohol: _____

Caffeine: _____

Tobacco: _____

Marijuana: _____

Prescription drugs for which you do not have a prescription: _____

Non-prescription drugs: _____

LIFESTYLE & FAMILY INFORMATION

1. What is going well in your life? _____

_____

_____

2. What hobbies or activities do you regularly engage in? _____

_____

_____

3. What *outdoor* hobbies or activities do you engage in (or have previously enjoyed)?_____

_____

_____

5. Please list any family members below:

	Living?	*Age*	*Medical illnesses or mental health diagnoses*
Mother:	Y N		
Father:	Y N		
Other parent/ guardian:	Y N		
Other parent/ guardian:	Y N		
Step Parent	Y N		
Step Parent	Y N		
Siblings & Others	Y N		
Siblings & Others	Y N		
Siblings & Others	Y N		
Siblings & Others	Y N		

Who do you currently live with? _____

_____

Are you currently involved in any divorce or custody proceedings? YES NO

If yes, please specify: _____

PRESENTING CONCERNS

1. Symptom Checklist: Please check all the following symptoms that you have experienced in either the last month or more than a month ago.

Please check both if you have experienced the symptoms recently *and* in the past.

☐ **= Recent (within the last month)** ○ **= Past (one month ago or more)**

- ☐ ○ Decreased appetite
- ☐ ○ Increased appetite
- ☐ ○ Significant weight loss
- ☐ ○ Significant weight gain
- ☐ ○ Depressed mood
- ☐ ○ Irritability
- ☐ ○ Feelings of worthlessness
- ☐ ○ Sleep difficulties
- ☐ ○ Loss of energy
- ☐ ○ Loss of interest in activities
- ☐ ○ Loss or decreased sexual interest
- ☐ ○ Lost or irregular menstrual cycle
- ☐ ○ Increased energy
- ☐ ○ Regular headaches or migraines
- ☐ ○ Nightmares
- ☐ ○ Substance abuse (alcohol or drugs)
- ☐ ○ Attention and concentration difficulties
- ☐ ○ Recurrent/excessive anxiety or worry
- ☐ ○ Feelings of restlessness
- ☐ ○ Muscle tension
- ☐ ○ Gastrointestinal issues
- ☐ ○ Trembling or shaking
- ☐ ○ Accelerated heart rate
- ☐ ○ Shortness of breath
- ☐ ○ Sweating
- ☐ ○ Chest pain
- ☐ ○ Nausea
- ☐ ○ Recurrent thoughts of death
- ☐ ○ Recurrent thoughts of hurting others
- ☐ ○ Seeing or hearing things that others do not
- ☐ ○ Paranoid thoughts

2. In the last two weeks, have you had suicidal thoughts (i.e., thoughts of killing yourself)?

Please circle one: YES NO

If you circled YES, please answer the questions below:

What is the frequency of these thoughts?

☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always

What is the duration of these thoughts?

☐ Seconds ☐ Minutes ☐ Hours ☐ Constantly

What is the intensity of these thoughts?

☐ Brief and fleeting ☐ Intense rumination ☐ Focused deliberation ☐ Constant

3. P*lease indicate if/when you have had any of the following experiences (check one per row).*

Have you ever...	***Never***	***In the Last Year***	***Over a Year Ago***	***Both***
...experienced a traumatic event that caused you to feel intense fear, helplessness, or horror?				
...been hospitalized for mental health concerns?				
...received treatment for alcohol or drug use?				
...purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, hair pulling, etc.)?				
...seriously considered attempting suicide?				
...made a suicide attempt? If yes, how many times? _____				
...considered seriously injuring another person?				
...had an unwanted sexual contact or experience?				
...felt you had an eating problem?				
...been prosecuted for criminal activity?				
...experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, authority figure)?				

4. **Please mark all of the items below that you are concerned about.** Feel free to indicate which of these items you would especially like to work on in therapy (by highlighting or circling).

- ☐ Aggression/violence
- ☐ Anger
- ☐ Anxiety, nervousness
- ☐ Career choices or uncertainty
- ☐ Computer or technology addiction
- ☐ Concerns re: environmental or social issues
- ☐ Cultural adjustment/ acculturation
- ☐ Death of a loved one
- ☐ Depression
- ☐ Discrimination/oppression
- ☐ Divorce/separation
- ☐ Drug and/or alcohol use
- ☐ Eating disorder or body image concerns
- ☐ Fears/phobias
- ☐ Fertility concerns
- ☐ Financial stress/concerns
- ☐ Flashbacks
- ☐ Gambling
- ☐ Identity concerns
- ☐ Isolation/loneliness
- ☐ Legal concerns
- ☐ Obsessions/compulsions
- ☐ Parenting concerns
- ☐ Perfectionism
- ☐ Relationship concerns
- ☐ School stress
- ☐ Self-esteem
- ☐ Self-harming behaviors
- ☐ Sexual trauma or assault
- ☐ Sexual problems
- ☐ Shyness/social discomfort
- ☐ Spiritual/religious matters
- ☐ Suicidal thoughts
- ☐ Trauma
- ☐ Work stress
- ☐ Other: _____

5. Please briefly state the reason(s) and/or concern(s) for which you are seeking therapy now:

_____

_____

_____

_____

6. What are your goals or hopes for therapy? _____

_____

_____

_____

_____

Thank you for taking the time to complete this confidential form.