CLIENT INFORMATION QUESTIONNAIRE

All Information Confidential

General Information Date ______________________________

Print Name____

DOB ______________________ Age _________________ Sex ☐ Female ☐ Male

(Whom may we contact in case of an Emergency)

Emergency Contact Name ____

Phone #________________________ Relationship______________________________

Current Family Doctor/Practice____

Other Therapist/Doctors____

Pharmacy Name/Location/Phone____

Do you have a WRAP (Wellness Recovery Action Plan) plan? ☐ No ☐ Yes

Do you have Advanced Directives? ☐ No ☐ Yes

1. To help us understand better what concerns you may have, please circle any of the following problems which pertain to you:

Nervousness	Anger	Loneliness
Depression	Self-Control	Inferiority Feelings
Fears	Unhappiness	Concentration
Shyness	Sleep	Education
Sexual Problems	Stress	Career Choices
Suicidal Thoughts	Work	Health Problems
Separation	Being a Parent	Temper
Divorce	Headaches	Nightmares
Finances	Tiredness	Marriage
Drug Use	Legal Matters	Children
Alcohol Use	Energy	Appetite
My Thoughts	Making Decisions	Stomach Trouble

2. Have you ever received mental health or substance abuse treatment? ☐ No ☐ Yes

☐ Inpatient ☐Outpatient

Place/Provider ____________________ Year(s) __________ Reason ____________________________

Place/Provider ____________________ Year(s) __________ Reason ____________________________

Place/Provider ____________________ Year(s) __________ Reason ____________________________

Place/Provider ____________________ Year(s) __________ Reason ____________________________

Place/Provider ____________________ Year(s) __________ Reason ____________________________

3. When were you last seen by a mental health professional? ☐ Not applicable

____

4. Do you drink alcohol? ☐ No ☐ Yes

Type ________________________ Amount ____________________________

Date of Last Drink __________________________

5. Have you ever had a problem with alcohol? ☐ No ☐ Yes

Describe ____

6. Have you ever had a problem with substance abuse (other than alcohol)? ☐ No ☐ Yes

Describe ____

7. Do you use tobacco in any form? ☐ No ☐ Yes

Describe ____

8. Current caffeine consumption (Soda, Coffee, Tea, Iced Tea, etc.)? ☐ No ☐ Yes

Amount ____

9. Do you take medications? Please include; Over the Counter (OTC) medications, herbal preparations, dietary supplements, etc.? ☐ No ☐ Yes

Drug	Dose	Frequency	Reason	Who Prescribed

10. Do you have any health problems? ☐ No ☐ Yes

Please list:

____

____

11. Have you had any major, non-psychiatric hospitalization? ☐ No ☐ Yes

Place | Year | Reason

____

____

____

____

12. Height ____________________ Weight ____________________

13. Have you any drug allergies or sensitivities? ☐ No ☐Yes

Please list: Drug | Symptom

____

____

____

____

14. Have you any other allergies or sensitivities (e.g. environmental, food, dye, latex, etc.) ☐No ☐Yes

Describe ____

____

15. In the past, have you ever been on medication for anxiety, depression, insomnia, etc.? ☐No ☐Yes

If yes,

Drug	When	How Long	Effectiveness	Side Effects	Why Discontinued

16. Do you have any family history of mental illness or substance abuse? ☐ No ☐ Yes

Describe____

____

____

To assist in completing a comprehensive assessment, we are required to ask the following questions regarding cultural/spiritual issues.

17. With what current support system do you identify? (Family, friends, church, culture values & beliefs, coworkers, activities and hobbies)

____

18. What is your religious affiliation?

____

19. What role does your religion/spirituality play in your life?

☐ Positive ☐ Negative ☐ Neutral

20. Are there any spiritual or cultural issues that you feel need to be taken into account in your treatment?

☐ No ☐ Yes If yes, please identify?

____

____

For statistical/funding purposes only, please complete the following questions:

Ethnicity: ☐Asian/Pacific Islander ☐Black ☐Hispanic ☐Mixed Races

☐Native American ☐Other ☐Unknown ☐White

Household Income: ☐ Annual ☐ Monthly ☐ Weekly (Total income that the **household earns**)

Amount $________________________

Supporting how many in the household (including yourself):________________________________

Client's Signature ____

____

Parent/Legal Guardian Signature/For Clients under 14 Date