CLIENT INFORMATION QUESTIONNAIRE
All Information Confidential

General Information

Print Name_____ DOB _____ Age _____

Sex: ☐ Female ☐ Male

Gender Identity:

☐ Female ☐ Intersex ☐ Male ☐ Nonbinary ☐ Other

☐ Prefer not to answer ☐ Transgender

Sexual Orientation:

☐ Bisexual ☐ Gay/Lesbian ☐ Hetero/Straight ☐ Other

☐ Pansexual ☐ Prefer not to answer

Whom may we contact in case of 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 check any of the following problems that pertain to you:

Anxiety	Children	Loneliness
Depression	Anger	Concentration
Fears	Self-Control	Education
Sexual Problems	Sleep	Work/Career Choices
Suicidal Thoughts	Stress	Health Problems
Separation/Divorce	Legal Matters	Nightmares

Other (Please Explain):

_____

_____

_____

2. Please check any of the following social needs that are impacting your ability to improve the quality of your life:

Housing Instability	Food Insecurity	Transportation Problems
Utility Help Needs	Interpersonal Safety	Financial Strain
Employment	Family/Community Support	Education
Physical activity	Substance Use	Disability

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

☐ Inpatient ☐ Outpatient

4. Do you drink alcohol? ☐ No ☐ Yes

Type _____ Amount _____

Date of Last Drink _____

5. Have you ever had a problem with alcohol or any substance of abuse? ☐ No ☐ Yes

Describe _____

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

Describe _____

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

Amount _____

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

Drug	Dose	Frequency	Reason	Who Prescribed

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

Please list:

_____

_____

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

11. Height _____ Weight _____

12. Do you have any allergies or sensitivities? ☐ No ☐ Yes

Please list:

_____

_____

13. 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

_____

_____

_____

14. 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.

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

_____

16. What is your religious affiliation?

_____

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

☐ Positive ☐ Negative ☐ Neutral

18. 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?

_____

_____

19. What ethnicity do you identify with? (Please choose one)

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

☐ Native American ☐ Other ☐ Unknown ☐ White

20. Household Income (As a not-for-profit agency we use this information for funding purposes only - all information is confidential).

Choose one (Total income that the **household earns**):

☐ Annual

☐ Monthly

☐ Weekly

Total Income Amount $_____

Supporting how many in the household (including yourself)

☐ 1 (Yourself)

☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

Client's Signature Date

Parent/Legal Guardian Signature/For Clients under 14 Date

Thank you for taking time to complete these documents. This information is very helpful for your therapist to assist in your treatment.