Questionnaire

Today's Date: _____

Name:

_____

First Middle Last

Address:

_____

Phone Number: (c) _____

Birth Date: _____ Age: _____ Male___ Female___

Occupation_____ Current Employer_____

Ethnicity/Race(circle any applicable): Caucasian___ Native American___ Asian___

Hispanic____ African American___ Multi Ethnic____

Have you had previous counseling? Yes___ No___

If so, with whom?(most recent)_____

Length of time?_____ Dates_____

May I contact this person? Yes___ No___ (If yes, please sign an authorization form)

Current Challenges / Concerns: State in your own words current challenges you are facing.

_____

_____

_____

_____

Check the boxes below that describe/relate to current issues listed above or are stand alone issues:

___Fear/Anxiety
___Depression
___Loss, grief
___Sadness
___Anger
___Stress
___Bitterness
___Loneliness

___Overthinking
___My thoughts
___Memory/Concentration
___Lack of Confidence
___Lack of self-control
___Lack of Satisfaction
___Lack of joy/happiness
___Suicidal thoughts/feelings

___Drug use
___Alcohol use
___Over-or-under eating
___Finances
___Vocational Direction
___Sleep Challenges
___Health Challenges
___Religious doubts/fears

Relationship with:

___Spouse/ Significant Other
___Parents
___Children
___Siblings
___God
___Friends
___Superiors
___Emotional

Abuse:

___Verbal ___Physcial ___Sexual

Other Issues not listed (specify):_____

_____

Parent/Family Information

Who raised you? ____ Biological ____ Step ____ Adoptive

Biological Parents Names:

Father_____ Married at the age of_____ Current Age____ Living?_____

Date of Passing _____ Divorced(when)?_____ at your age of_____ Remarried in_____

Mother_____ Married at the age of_____ Current Age____ Living?_____

Date of Passing _____ Divorced(when)?_____ at your age of_____ Remarried in_____

Parents Names: (Please indicate whether Step☐ or Adoptive☐)

Father_____ Married mother(when)_____ at your age of_____ Current Age_____

Living?____ Date of Passing _____

Mother_____ Married Father(when)_____ at your age of_____ Current Age_____

Living?___ Date of Passing _____

Brothers and Sisters (list by birth order and include step siblings)

Name	**Gender**	**Age Now**	**Deceased?**	**Date of Death**

Parenting was: (check one)

☐ Authoritative -High Control, parent driven, one way communication, and rules without relationship

☐ Permissive -Low control, child driven, rarely were rules enforced, and much freedom

☐ Disengaged -Very little guidance, indifferent to needs, uninvolved, and minimal relationship

☐ Balanced –Set clear rules/expectations and freedom to be independent, open communication, and solving problem with child

Home Atmosphere was: (check all that apply)

☐ **Caring** ☐ **Critical** ☐ **Hostile** ☐ **Religious** ☐ **Encouraging** ☐ **Perfectionistic**

☐ **Cooperative** ☐ **Degrading** ☐ **Disunified**

Marriage / Significant Relationship Information

Current Relationship Status:

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Engaged ☐ In a relationship

Current relationship:

Name:_____ Age: _____

Occupation: _____

Spouse's Education (highest education level): _____

How long have you been in this relationship? _____

Date of Marriage: _____

Ages when married/entered into relationship: Husband _____ Wife _____

Children of this relationship:

Name	**Age**	**Gender**	**Now lives with you?**

Any legal action? Indicate below:

Separation filed by: ☐ You ☐ Spouse Date: _____

Divorce filed by: ☐ You ☐ Spouse Date: _____

Previous Relationship:

Name: _____

Occupation: _____

Ages when married/entered into relationship: Husband _____Wife _____

Date of marriage: _____

Reason for termination: Death____ Divorce: Date of termination _____

Length of relationship: _____ Legal action by: You___ Spouse___

Children of this relationship:

Name	**Age**	**Gender**	**Now lives with you?**

Names of Close Friends/Mentors:

_____ _____

_____ _____

Spiritual Life Information

What is your spiritual background? _____

_____

Do you presently have a church affiliation? If yes, name of church:_____

How often do you attend? (check one) ☐ Weekly ☐ Monthly ☐ Seldom ☐ Never

Household Information

Who lives at your address?	Name	Age	Gender	Relationship

- Has anyone in your immediate family or family history suffered from mental health issues or addictions?Ex. Depression, Anxiety, Bi-Polar, Schizophrenia, Alcohol or Drug Abuse
  If so, please describe:_____
- Do any members of your family suffer from health or physical challenges/disabilities? Ex. Diabetes, IBS, Cancer, Asthma, Chronic headaches, High blood pressure etc.?
  If so, please describe: _____

Education Information

- What is the highest academic level you have achieved?

  _____

- Describe any problems you encountered during your educational experience:

  _____

- Describe any vocational or specialized training received:

  _____

- How do you feel about your educational achievements?

  _____

Physical Health

If you've experienced any of the following, please check mark the issue and indicate if this happens regularly with an "R" or "S" for sometimes right next to the check mark.

___Nervousness
___Headaches
___Exhaustion
___Persistent cough
___Muscle tension/cramps
___Sleeping difficulties
___Loss of appetite
___Exaggeration of appetite
___Cold hands/feet
___High Blood Pressure
___Grinding of teeth
___Clenching of jaw
___Chronic pain
___Allergies
___Indigestion
___Nausea
___Diarrhea
___Drug dependence
___Shortness of breath
___Migraine headaches
___Chest pains
___Skin problems
___Digestive Issues
___Sexual difficulties
___Overweight
___Underweight
___Heart racing
___Sinus congestion
___Colitis
___Asthma
Other_____

Do you currently see a doctor? If not when is the last time you saw a medical professional? _____

What did you or do you see them for?_____

When is the last time you had a physical and/or bloodwork:_____

Are you on any medications? If so, please list_____

Do you currently or have you seen a psychiatrist in the past?_____

If so, when is the last time you saw someone?_____ Name?_____

Do you take any medications? If so, what medications:

Prescriptions: _____

Over the Counter_____

Have you seen any other health and wellness professionals or pursued other therapies?(Ex. Life Coach, Educational Consultant, Dietitian/Nutritionist, Physical Therapist, Neurofeedback, Herbalist, Naturopathic Doctor, or Supplements)

If so please indicate who you saw, what therapies you pursued, and for what:

_____

Client Signature_____ Date_____