

## Psychotherapy Client Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### REFERRED BY:

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_

May I inform this person that you have consulted with me? \_\_\_\_\_

\_\_\_\_\_  
Your Signature

### CONFIDENTIALITY STATEMENT:

State law and professional ethics require therapists to maintain confidentiality except for the following situations:

1. If there is suspected child abuse, elder abuse, or dependent adult abuse.
2. "Tarasoff" and "Ewing" situations in which serious threat to a reasonably well-identified victim is communicated to the therapist.
3. When threat to injure or kill oneself is communicated to the therapist.
4. If you are required to sign a release of medical records by your medical insurance.
5. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. **Think carefully and consult with an attorney before you sign away your rights.** We can discuss some foreseeable possibilities together.
6. Clients being seen in couple, family, and group work are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute

confidentiality) when disclosing private information to other participants in your treatment process. Secrets cannot be kept by the therapist from others involved in your treatment process.

7. I may at times consult with professional colleagues about our work without asking permission, but your identity will be disguised.

8. My personal secretary and office manager have access to locked and coded records but are legally charged with confidentiality.

9. Clients under 18 do not have full confidentiality from their parents.

10. It is also important to be aware of other potential limits to confidentiality that include the following:

- All records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances. Most records are stored in locked files but some are stored in secured electronic devices.
- Cell phones, portable phones, faxes, and e-mails are used on some occasions.
- All electronic communication compromises your confidentiality.

## **1. GENERAL**

**A. Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_ **E-Mail:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Place of Birth:** \_\_\_\_\_

**B. What is your present living situation?** \_\_\_\_\_

\_\_\_\_\_

**C. Names and ages of children**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_  
Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

**D. Give a short history of your closest interpersonal relationships:**

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Education: \_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_

Currently working: \_\_\_\_\_

What is your present job situation? \_\_\_\_\_  
\_\_\_\_\_

**2. PROBLEM AREA**

**A. State in your own words the nature and history of your chief complaint:**

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**B. Present interests, hobbies, activities:** \_\_\_\_\_

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**C. How is most of your free time occupied?**

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**D. What are your life goals?**

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**E. What are your five greatest fears?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**3. FAMILY HISTORY**

**A. Father's name:** \_\_\_\_\_

Age: \_\_\_\_\_ Health: \_\_\_\_\_

If deceased, age and cause of death: \_\_\_\_\_

\_\_\_\_\_

Your age at time of father's death: \_\_\_\_\_

**Give a description of your father's personality:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ **B. Mother's name:**

\_\_\_\_\_

Age: \_\_\_\_\_ Health: \_\_\_\_\_

If deceased, age and cause of death: \_\_\_\_\_

\_\_\_\_\_ Your

age at time of mother's death: \_\_\_\_\_

**Give a description of your mother's personality:**

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**C. Brothers/Sisters (Names, sex, age, and something about each):**

[Are there significant others from your growing up years?]

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**D. Who are the most important people in your life? Describe.**

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**Previous Medical, Psychiatric, and Psychotherapy Contacts**

**E. Have you ever been in psychotherapy before?** \_\_\_\_\_

If yes, when? \_\_\_\_\_

May I contact your previous therapist(s)? \_\_\_\_\_

Therapist: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Therapist: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**F. Have you ever been hospitalized for an emotional problem?**

If yes, when, where, and how long? \_\_\_\_\_

\_\_\_\_\_

If yes, when, where, and how long? \_\_\_\_\_

\_\_\_\_\_

**G. Have you ever made a suicide attempt? If yes, describe it, when, and the circumstances leading up to the attempt.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**H. Have any close relatives been treated for psychiatric problems?**

If yes, please specify: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I. Has any relative of yours committed suicide?**

If yes, please specify: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**J. Give details of all forms of abuse you were subject to in childhood (neglect, verbal violence, sexual).**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**K. Give a brief history of any litigation you have been involved in regarding child custody, divorce, liability, or medical malpractice.**

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**4. SELF-DESCRIPTION**

Give a word-picture of yourself. Describe yourself in terms of how you presently feel and see yourself (include both negatives and positives):

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**5. MEDICAL HISTORY**

**A. Have you had any of these childhood illnesses?**

	<b>NO</b>	<b>YES</b>	<b>DON'T KNOW</b>
Measles	___	___	_____
Mumps	___	___	_____
Whooping cough	___	___	_____
Chicken pox	___	___	_____
Rheumatic fever	___	___	_____
Rubella (German measles)	___	___	_____

**Please list all medical hospitalizations and operations. Give diagnoses and dates:**

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**B. Have you ever suffered from any of the following illnesses?**

	NO	YES	DATE OF ONSET
Cancer	___	___	_____
TB	___	___	_____
Diabetes	___	___	_____
Thyroid trouble	___	___	_____
Kidney trouble	___	___	_____
High blood pressure	___	___	_____
Eye trouble	___	___	_____
Heart trouble	___	___	_____
Neurological disease	___	___	_____
Ulcers	___	___	_____
Head injury	___	___	_____
D.T.'s	___	___	_____
Allergies	___	___	_____

List all allergies: \_\_\_\_\_

\_\_\_\_\_ Any

other serious illnesses? \_\_\_\_\_

**C. Family History**

Have any of your blood relatives suffered from any of the illnesses listed above? If yes, please specify ailment and relative:

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Any other serious illness? \_\_\_\_\_

**D. Drug/Medication History**

Because many drugs (legal and illegal) have psychological effects, it is important for me to know what drugs you are *currently* taking and/or *have taken in the past*. This information will remain strictly confidential, but it is very important for me to know before you begin therapy so that an accurate assessment of your problem and situation can be made. Please list *all* legally prescribed and illegal drugs ever used (past or present) and describe how often you use them and what effects you seek:

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**Have any of these drugs been prescribed by a physician?**

Yes \_\_\_\_\_ No \_\_\_\_\_ If so, which drugs and for what reason?

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**E. Nutrition**

Is your diet unusual in any way? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, how? \_\_\_\_\_

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**F. Symptoms**

Check any of the following symptoms that apply to you at this time. Also indicate when any of these symptoms have applied to you in the past.

Hair falling out	_____	Fainting spells	_____
Weight gain	_____	Difficulty sleeping	_____
Fatigue	_____	Drinking too much fluid	_____
Constipation	_____	Blurred vision	_____
Dry skin	_____	Deafness	_____
Weakness	_____	ringing in ears	_____
Weight loss	_____	Chest pain	_____
Tremor	_____	Shortness of breath	_____
Big appetite	_____	Tingling of hands or feet	_____
Fast heart beat	_____	Ankle swelling	_____
Diarrhea	_____	Indigestion	_____
Poor appetite	_____	Nausea or vomiting	_____
Headaches	_____	Urinary difficulties	_____
Dizziness	_____	Problems with sexual organs	_____

**G. Menstrual History, Issues, or Problems:** \_\_\_\_\_

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**H. Smoking and Drinking**

Do you smoke (anything)? \_\_\_\_\_ What? \_\_\_\_\_ How much? \_\_\_\_\_

Frequency? \_\_\_\_\_ Do you drink alcohol? \_\_\_\_\_ If yes, how

much? \_\_\_\_\_ What happens to you when you smoke or drink, that is, what does it do

for you? \_\_\_\_\_

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**Describe any physical symptoms at all that you have when you smoke or drink.**

**I. What kind, and how much physical exercise do you get?**

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**J. Describe the spiritual/religious aspects of your life:**

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**K. Have you ever been hypnotized? If so, for what and what were the results?**

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**L. Have you ever been on worker's comp or disability? For what, how long, results?**

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**M. In case of emergency, please notify one of the following three people: May I have your permission to inform one or all of these people if you are ever in danger?**

Yes \_\_\_\_\_ No \_\_\_\_\_

