INFORMATION QUESTIONNAIRE

The information on this questionnaire is confidential.

Part I

Name: _____ Today's Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Can messages be left at this number? ___ Yes ___ No
Work Phone: _____ Can messages be left at this number? ___ Yes ___ No
Mobile Phone: _____ Can messages be left at this number? ___Yes ___ No
Age:_____ Date of Birth: _____ Social Security Number: _____
Referred by: _____
Person to contact in case of emergency:
Name: _____ Relationship to you: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Present Occupation: _____ Total hours/week _____
Employer: _____
Address: _____
City: _____ State: _____ Zip: _____

Part II

Highest Level of Education: _____
Last school attended: _____
Are you currently enrolled in school? ___Yes ___ No
If so, where and what is your course of study? _____
_____
Relationship Status: ___ Single ___ Married ___Divorced ___Co-habitating
___ Same-sex Partner ___ Dating ___Widow/Widower
(If applicable) How long have you been in your present relationship? _____
Please list the people currently living with you and their relationship to you:
_____
_____
_____
_____
Do you have any children? ___Yes ___ No
If so, please list their names and ages below:
_____
_____
Describe any illnesses, injuries, or operations you have had (please include dates):
_____
_____
_____
_____

Please list any mental health professionals you have consulted in the past:
Name: Problems Addressed: Dates of Treatment:

_____
_____
_____
_____

What medications or special diets are you currently using?

_____
_____

Have any relatives been treated for any serious medical, emotional or substance abuse problems?

_____
_____
_____

Do you have any limiting physical or intellectual conditions?

_____
_____

Briefly describe the problem which prompted you to seek counseling at this time.

_____
_____
_____
_____
_____
_____
_____

How have you addressed this issue thus far?

_____
_____
_____

Are there any other professional persons (physicians, clergy, school personnel, law enforcement Personnel, etc.) familiar with your current difficulties? If so, please list:

_____
_____
_____

What would you like to be different in your life as a result of therapy?

_____
_____
_____
_____

Do you have any hobbies or special interests?

_____
_____
_____

What do you do for relaxation and recreation?

_____
_____
_____

How do you cope with stress?

_____
_____

Are you currently involved in any legal proceedings (divorce, custody hearings, civil suit, pressing criminal charges, being charged with a crime or misdemeanor, etc.)? ___ Yes ___ No.
If yes, please explain briefly: _____
_____

Do you anticipate any such involvement in the near future? ___ Yes ___ No

Please indicate the extent to which you have used the following substances in the past year:

Substance	Yes/No	If yes, how much? How often?
Caffeine		
Nicotine		
Alcohol		
Marijuana		
Cocaine		
Heroin		
LSD/hallucinogens		
Other:		

Please answer yes or no to the following questions:

During your childhood or adolescence, did either biological parent have a problem with alcohol? _____

Did either biological parent abuse other chemical substances (cocaine, marijuana, heroin, Prescription drugs, etc.)? _____

During your childhood or adolescence did you have a guardian or step-parent who abused alcohol or other chemical substances? _____

When you were a child or adolescent, did an adult overly criticize you, focus on your failures, yell, scream, and/or swear at you? _____

When you were a child or adolescent, did an adult punch, bite, kick, burn, or beat you? _____

When you were a child or adolescent, did someone fondle you, expose themselves to you and you felt frightened, exploit you sexually, and/or attempt sexual contact when you did not want to Participate in?_____

As an adult, has someone overly criticized you, focused on your failures, yelled, screamed, and/or sworn at you? _____

As an adult, has someone fondled you, exposed themselves to you and you felt frightened, exploited you sexually, and/or attempted sexual contact when you did not want to participate? _____

Problem Areas: In the following list, place a check mark next to each item which identifies an area of concern to you. Place two checks by those items which are most important. (You may Add comments after areas checked.)

___ Anger ___ Religious/Spiritual concerns
___ Anxiety ___ Sexual concerns
___ Depression ___ Sexual orientation
___ Domestic violence ___ Thoughts of suicide
___ Education/school problems ___ Trouble making decisions
___ Eating difficulties ___ Unhappy most of the time
___ Fearfulness ___ Use of alcohol/drugs
___ Financial problems ___ Use of alcohol/drugs by
___ Health concerns significant other
___ Marital concerns ___ Thoughts of harming
___ Problems with partner/significant other someone
___ Problems with children ___ Vocational goals
___ Problems with parents ___ Workplace issues
___ History of physical abuse ___ History of sexual abuse
___ History of verbal/emotional abuse ___ Substance abuse by
___ Victim of crime or assault parent or guardian
___ Other (please specify)

Is there anything else that you feel is important and that you would like for me to know?
_____
_____
_____
_____
_____