

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: _____

INFORMATION QUESTIONNAIRE

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-habiting

____ 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:

<u>Substance</u>	<u>Yes/No</u>	<u>If yes, how much?</u>	<u>How often?</u>
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? _____

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?
