Client History Questionnaire

Name: **Date:**

Please explain why you are seeking our services at this time: (just type in the gray)

How long have you been experiencing these problems? What has been going on in your life?

How are they affecting you daily life? Are there any limitations because of these problems?

Why are you seeking treatment now? Who referred you and why?

Are there any specific problems or situations recently or currently that are stressing or impacting your life at this time? (Double click the box with the LEFT KEY and select check, or just highlight your answer)

☐ **No** ☐ **Yes (specify):**

☐ Life changes (graduation, job, relationships) ☐ Financial challenges ☐ Drugs/alcohol issues

☐ Health concerns ☐ Relocation ☐ Friendships ☐ Arrest or legal challenges ☐ Child/Parent issues

☐ Family stressors ☐ Marital stressors ☐ Work issues/situations impacting personal life

☐ Mental Health problems:

☐ Trauma/significant life events/critical incident ☐ Significant loss/grief ☐ PTSD/abuse

☐ Pain/injury/health status changes

Please describe:

How much do you want to be in treatment and possibly change something about yourself or your life? (It's okay to be honest). What do you think the biggest challenge might be?

How would you like us to help you with this problem?

Are there any other individuals who are also involved in this problem and who might also be involved in your treatment? ☐

RISK ASSESSMENT:

Is this an emergency situation? □ No □ Yes, _ __
Are you currently suicidal? □ No □ Yes, __
Have you ever been suicidal before? □ No □ Yes, __ ____
Have you ever made an attempt? □ No □ Yes, _
Does your drug/alcohol use cause problems with your job, family or health? □ No □ Yes, __
Do you ever harm yourself on purpose? □ No □ Yes, _
Have you ever been hospitalized for mental health reasons? □ No □ Yes, __

Are you currently under the care of any other Therapist, Physician or Psychiatrist? □ Yes □ No
Who?
For what reasons?
Would you like us to notify them about your involvement here? □ No □ Yes, (if yes please provide their name, city/address):

Are you currently taking medication for anxiety, your nerves, depression, or other mental health or emotional problems?
□Yes □ No
Name of Physician who prescribed it:
What medications and dosages?

For what reasons and how long have you been on it?
Was it/Is it helpful?
Will you allow your therapist to have contact with your physician? ☐Yes ☐No

When was your last medical examination? ____/___/____

Do you have any significant health problems that your therapist should know about? ☐Yes ☐No
Please specify:

Do you have any significant health concerns that you worry about? What is the concern you have?

Have you ever seen a therapist, psychiatrist or counselor before? ☐Yes ☐No
Who did you see?
For what reasons?
Where and when?
Was it helpful?
Were you given a diagnosis?

Have you ever participated in a program at a hospital or been hospitalized for psychiatric reasons before? ☐No ☐Yes
Where?
For what reasons?
Where and when?
Was it helpful?

Do you attend any support groups? ☐No ☐Yes Which ones?
Do you follow the recommendations? ☐No ☐Yes
Do you have a sponsor?

Background Information:

Are you: ☐Single ☐Divorced ☐ In a committed relationship/domestic partnership
☐Married ☐Separated ☐ Remarried ☐Widowed

Do you live: ☐Alone ☐With a roommate ☐With my significant other
☐Parents At school ☐With my family/spouse

What is your race/ethnic origin? (optional)
☐Caucasian ☐American Indian Other: _
☐African American ☐Asian
☐Hispanic ☐Bi-racial

Do you have children? ☐Yes ☐No

What level of education have you completed?

Do you have any specialized education or training?

Are you employed? ☐Yes ☐ No
What kind of work do you do?
How long have you held this job?
Do you like what you do for fun, hobbies or relaxation? ☐Yes ☐No

Do you have family history of traumatic events, abuse, neglect, significant accidents or injuries, family life events, death or loss or physical, mental health or emotional problems? ☐Yes ☐No (specify)

Do you have any family history of alcohol or substance abuse? ☐Yes ☐No (specify)

What do you think is the root of the problems you are experiencing now? How long have you be struggling with this problem (problems)? How do they interfere with your life? What are you doing to try to manage them?

Have *you* experienced any specific early childhood or other life events, illness or problems that you have struggled with that your therapist should know about? (This includes abuse, injury, illness, divorce, accidents, major losses or other major incidences.) ☐Yes ☐No (specify)

Problems & Concerns

Directions: Please read and answer the questions below regarding specific problems or symptoms. If you respond YES to the numbered questions, please complete the additional questions in that section. If you answer NO to the **bolded & numbered question**, **please skip to the next numbered question**. Feel free to add any comments as needed.

1. Would you describe your mood as generally sad, down in the dumps or depressed? ☐No ☐Yes

If Yes:

For how long? _

Is your mood: ☐ sad ☐ anxious ☐ irritable ☐ other _

Did this happen after a pregnancy or childbirth?	☐ Yes ☐ No
Have you ever been treated for depression?	☐ Yes ☐ No
Have you experienced a significant change or loss within the past 12 months?	☐ Yes ☐ No
Have you ever experienced an episode like this before?	☐ Yes ☐ No
Have you experienced any weight loss or change in your appetite?	☐ Yes ☐ No
Do you think about death or have suicidal thoughts currently?	☐ Yes ☐ No
Have you ever made a suicide attempt before?	☐ Yes ☐ No

Over the past 14 days, indicate if you've had any of these problems and how much it has bothered you:	**Not at all**	**Several days**	**More than half the time**	**Nearly every day**
Little interest or pleasure in doing things that usually bring me pleasure	0	1	2	3
Feeling down depressed or hopeless	0	1	2	3
Trouble falling asleep	0	1	2	3
Trouble staying asleep	0	1	2	3
Waking up early and not being able to go back to sleep	0	1	2	3
Sleeping too much	0	1	2	3
Feeling tired or having too little energy	0	1	2	3
Poor appetite and decreased eating	0	1	2	3
Eating too much	0	1	2	3
Trouble concentrating or paying attention	0	1	2	3
Slowed down physically	0	1	2	3
Agitation, restless or fidgety	0	1	2	3
Feelings of worthlessness or guilt?	0	1	2	3
Difficulty with concentration or indecisiveness?	0	1	2	3
Crying more than usual or being unable to cry at all	0	1	2	3
Feeling blue, down in the dumps or sad?	0	1	2	3
Feeling anxiety, restless or difficulty calming yourself?	0	1	2	3
Hurt yourself to feel better?	0	1	2	3
Thinking that you'd be better off dead or going to sleep and not caring if you wake up	0	1	2	3
These problems have interfered with my job, relationships or home life	0	1	2	3

2. Would you describe your mood as manic, euphoric, irritable, or higher than normal? ☐ No ☐ Yes

If Yes:

For how long? _____

Have you ever been treated for manic-depression (Bipolar) before? ☐ Yes ☐ No
Have you ever experienced a manic episode before? ☐ Yes ☐ No
Have you ever experienced a depressive episode before? ☐ Yes ☐ No
Do your thoughts race? ☐ Yes ☐ No
Do you need less sleep than you usually do? ☐ Yes ☐ No
Do other people tell you that you talk too fast or they can't get a word in? ☐ Yes ☐ No
Are you more destructible or have trouble paying attention than usual? ☐ Yes ☐ No
Are you finding yourself more productive that usual? ☐ Yes ☐ No
Are you finding that you are more impulsive and/or making risky choices? ☐ Yes ☐ No

3. Have you believed things that others told you weren't real or have you ever seen things others couldn't or heard things others couldn't? ☐ No ☐ Yes

If Yes:

Were you treated for it? ☐ Yes ☐ No

4. Do you have times when you have episodes of anxiety, panic or fear in daily life? ☐ No ☐ Yes

If Yes:

For how long? _____

Are you always or most always anxious or worried? ☐ Yes ☐ No
Do others tell you that you're worried about things that aren't real? ☐ Yes ☐ No
Do people in your family (parents, grandparents) have anxiety or panic too? ☐ Yes ☐ No
Have you ever been treated for anxiety, panic or related problems? ☐ Yes ☐ No
Have you ever experienced an anxiety or panic attack? ☐ Yes ☐ No
Do you have anxiety about being in situations or places where leaving might be difficult, embarrassing, or where you might have an anxiety or panic attack? ☐ Yes ☐ No
Do you change your plans or avoid situations or activities because of anxiety? ☐ Yes ☐ No
Do you worry about having an anxiety or panic attack? ☐ Yes ☐ No
Do you have fears about certain objects or situations? ☐ Yes ☐ No
Do you think your fear is excessive or unreasonable? ☐ Yes ☐ No
Do you worry about reactions of others or being humiliated in front of others? ☐ Yes ☐ No
Would you describe yourself as generally anxious or worried about a number of events or situations in your life? ☐ Yes ☐ No
Have you ever experienced the following symptoms during an anxiety or panic attack?

☐ racing heart	☐ feel unreal	☐ shortness of breath
☐ sweating	☐ faint or dizzy	☐ fear of dying
☐ choking	☐ chest pain	☐ fear of going crazy
☐ shakiness	☐ nausea	☐ fear of losing control
☐ pounding heart	☐ racing thoughts	☐ feeling like you have to escape

5. Do you find yourself having recurrent thoughts or impulses that won't go away and/or repetitive act or actions (including praying, counting, etc.) in response to your thoughts? ☐ No ☐ Yes

If Yes: For how long? _____How much time during your day do you do these behaviors? _____

Have you ever been treated for obsessional thinking or compulsive behaviors? ☐ Yes ☐ No
Do you have specific thoughts that recur, and won't go away? ☐ Yes ☐ No
Do you have specific behaviors that you feel you have to do? ☐ Yes ☐ No

Do you experience significant fear or anxiety if these behaviors do occur? ☐ Yes ☐ No
Do other people tell you that your behaviors are strange or odd? ☐ Yes ☐ No
Do you find yourself engaging in tapping, checking or other behaviors which takes you away from things you should otherwise be doing? ☐ Yes ☐ No
Do people get mad at you because of the amount of time you spend in your behaviors, which may make you spend more time in behaviors? ☐ Yes ☐ No
Do you wash your hands, or clean a great deal to manage feelings? ☐ Yes ☐ No
Do you check things repeatedly as a behavior to manage feelings? ☐ Yes ☐ No
Do you count things as a behavior to manage feelings? ☐ Yes ☐ No
Do you become anxious, worried or afraid if you can't do these behaviors? ☐ Yes ☐ No

6. Have you experienced a traumatic event or series of events in your life, or been emotionally, sexually or physically abused? ☐ No ☐ Yes

If Yes: Approximately, at what age range or ages did this occur? _____ ☐ Yes ☐ No
Do you experience recurrent or intrusive distressing thoughts about it? ☐ Yes ☐ No
Do you experience intense fear or helplessness when faced with situations that seem familiar or similar? ☐ Yes ☐ No
Do you ever feel like the events were happening again? ☐ Yes ☐ No
Do you seem to lose time or have unexplained periods of time? ☐ Yes ☐ No
Have you ever experienced a flashback? ☐ Yes ☐ No
Do you experience emotional numbness and feeling disconnected? ☐ Yes ☐ No
Do you avoid things because they remind you of the traumatic event? ☐ Yes ☐ No
Are you always on guard for things to go wrong? ☐ Yes ☐ No
Do you use food as a way to manage feelings? ☐ Yes ☐ No
Do you use alcohol or drug to manage feelings? ☐ Yes ☐ No
Do you ever self-injure (cut, burn, scratch, etc.) to manage feelings? ☐ Yes ☐ No

7. Have you been told that you are too thin, or do you have a great fear of becoming fat? ☐ No ☐ Yes

If Yes:
Have you ever been treated for anorexia before? ☐ Yes ☐ No
Do you work to keep your weight low, or keep trying to lose more weight? ☐ Yes ☐ No
Has your period stopped? ☐ Yes ☐ No
Do you maintain a limited diet? What do you restrict?_____ ☐ Yes ☐ No
Do you exercise to manage your weight? ☐ Yes ☐ No
What do you do and how often?
Do you ever binge? ☐ Yes ☐ No
Do you use diuretics, laxatives or diet pills/products to lose weight? ☐ Yes ☐ No
Do you use alcohol or drugs as a way to manage feelings? ☐ Yes ☐ No
Do you ever self-injure (cut, burn, scratch, etc.) to manage feelings? ☐ Yes ☐ No

8. Do you have episodes of binge eating? ☐ No ☐ Yes

If yes:
Have you ever been treated for compulsive overeating or bulimia? ☐ Yes ☐ No
Do you experience a feeling of being out of control with food? ☐ Yes ☐ No
Do you try to prevent weight gain after eating? ☐ Yes ☐ No
What do you restrict?_____
Do you exercise to manage your weight? ☐ Yes ☐ No
What do you do and how often?_____

If you indicated YES to questions 7 or 8 please complete the following:

	Yes	No
Are you satisfied with your nutrition and eating patterns?		
Do others comment about your eating patterns, body size and your weight?		
Do you ever eat in secret?		
Do you avoid eating around other people?		
Does your weight interfere with how you relate to people?		
Do you use diuretics, laxatives or diet pills/products to lose weight?		
Do you use alcohol or drugs as a way to manage feelings?		
Do you ever self-injure (cut, burn, scratch, etc.) to manage feelings?		
Do you constantly criticize yourself about your body size, weight, or food behaviors?		
Does your weight interfere with how you feel about yourself?		
Do you constantly check the size of different parts of your body?		
Would you say food dominates your life?		
Do you think you are fat when everyone else says you are thin?		
Do you make yourself sick because you feel uncomfortably full?		
Do you use food (or restrict, exercise or compensate) when you feel emotionally overwhelmed or stressed?		

9. Do you gamble? **☐ No ☐ Yes**

If Yes:

Have you ever tried to stop or cut down? ☐ Yes ☐ No
Are you preoccupied with gambling? ☐ Yes ☐ No
Do you gamble to escape your problems? ☐ Yes ☐ No
Do you ever lie to people to hide your losses or extent of gambling? ☐ Yes ☐ No
Has your gambling ever caused you financial trouble? ☐ Yes ☐ No
Have you ever done anything risky or illegal to get money to gamble? ☐ Yes ☐ No
Does your significant other know the extent of what you spend? ☐ Yes ☐ No
Do you work extra hours to fund your gambling expenditures? ☐ Yes ☐ No

11. Do you use street drugs, IV drugs or prescription drugs (beyond their prescribed use)? ☐ No ☐ Yes

What do you use?_____
How much and how often?_____
When was the last time you used?_____

12. Do you use drugs or alcohol to help you manage or cope with life? **☐ No ☐ Yes**

If Yes:

Have you ever been treated for substance abuse? ☐ Yes ☐ No
Have you noticed that you need more to get the desired effect? ☐ Yes ☐ No
Do you have withdrawal symptoms? ☐ Yes ☐ No
Do you use anything to help you manage the withdrawal symptoms? ☐ Yes ☐ No
Do you ever end up using mare or longer that you had intended? ☐ Yes ☐ No
Have you ever tried to cut down or know that you should but can't? ☐ Yes ☐ No
Do you spend a great deal of time and effort to get the drug? ☐ Yes ☐ No
Do you have hangovers? ☐ Yes ☐ No
Do you miss work or other events because of hangovers or use? ☐ Yes ☐ No
Do you continue to use even though you have noticed physical problems? ☐ Yes ☐ No

Have your substance use caused problems with family members or friends? ☐ Yes ☐ No
Do you have blackouts? ☐ Yes ☐ No
Have you ever had a DUI or substance related legal problems? ☐ Yes ☐ No

Questions	0	1	2	3	4
1. How often do you have a drink containing alcohol? SPECIFY:	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
AUDIT/ WHO Scores 8-15, risk for hazardous use; 16-19 increased risk; 20 or higher alcohol dependence					

Please answer the questions, rate the item as it fits your personality or descriptions. I think that I can be described as, or I think others would say that:	**Not at all**	**A little bit**	**Somewhat or Sometimes**	**Yes this describes me well**
I'm not very trusting.	0	1	2	3
My friendships don't seem to last very long.	0	1	2	3
I plan things out before I do them because I don't want to make a mistake.	0	1	2	3
People say I am too dramatic and am a "drama queen."	0	1	2	3
People say I am rigid or inflexible.	0	1	2	3
I can't stand being alone.	0	1	2	3
I don't care what people say or think about me.	0	1	2	3
I have to constantly prove myself to people who don't deserve it.	0	1	2	3
I have to be in a relationship to feel good about myself.	0	1	2	3
I don't like getting consequences for my behaviors (getting in trouble).	0	1	2	3
My appearance or weight dictates how I feel about myself.	0	1	2	3
I want people to pay attention to me. I like it.	0	1	2	3
I feel guilty about things in my life.	0	1	2	3

I am too forgiving of others, but I'd rather be liked than be right.	0	1	2	3
I don't have any regrets about my decisions and actions.	0	1	2	3
I have been impulsive or reckless and had difficulties because of it.	0	1	2	3
I distrust people or am suspicious about others intentions.	0	1	2	3
I really don't care about what the rules are	0	1	2	3
I hold grudges and I know there will be pay back some day.	0	1	2	3
I don't know who I really am, my identity seems unclear.	0	1	2	3
I don't think I am a valuable or worthwhile person.	0	1	2	3
My self-esteem or value as a person is pretty low.	0	1	2	3
I am good at a lot of things.	0	1	2	3
I like being the center of attention.	0	1	2	3
Being in control at all times is very important to me.	0	1	2	3
People say I do things just for attention.	0	1	2	3
People think I don't have any problems. I am good at keeping things private.	0	1	2	3
If people really knew me, I'm afraid they wouldn't like me.	0	1	2	3
I am good at making things work around me, I am a good problem solver.	0	1	2	3
Compared to others, I can do many things faster, better and more effectively.	0	1	2	3
I'd be lost without my spouse/significant other. I'm not good on my own.	0	1	2	3
I really don't like getting "in trouble" for anything.	0	1	2	3
I am too trusting.	0	1	2	3
I can be impulsive, not always in a good way.	0	1	2	3
I care about what people (in general) think or say about me.	0	1	2	3
I don't want or enjoy close relationships, I'd rather be alone.	0	1	2	3
Friendships and relationships are difficult for me.	0	1	2	3
I don't have many close relationships, but don't really want them either.	0	1	2	3
I have been told that I am moody or temperamental.	0	1	2	3
I like to do risky or dangerous things because they give me a rush.	0	1	2	3
I have been told that I overreact to things.	0	1	2	3
What I think or how I think about things can be distorted or not true.	0	1	2	3

I think my biggest problem or issue that I need to address immediately and most importantly work on is:

What is the biggest part of that problem that you would like to address about that concern?

And two other treatment goals I want to work on:

I also want to work on or resolve the following problems (please list no more than three):

In order to work on or resolve those problems, I am willing to:

I am *not* willing to change or work on (specific issues, behaviors, habits, beliefs):

In preparing to work on these issues, I want my therapist to know (what specifically):

Client Signature: Date:

Therapist Signature: Date: