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Questionnaire

Directions: Please fill out all requested information to the best of your ability. Note that none of this information is required, but that you are choosing voluntarily to answer any or all of the following questions. This document will be kept confidential according to state rules and regulations. Please email this form back to me before our first session. The more info you provide, the better I can understand what you are going through and assist you.

Personal Information

Name: _____ Phone #: _____

Cell#: _____

Address: _____

City_____ Zip_____

Gender: _____ Birthdate: _____ Age: _____

Referred by:

Disclosure Statement explained & signed? Yes or No

Release of Information signed (for whom)?

Permission to Text? Yes No

In case of emergency, whom may we contact? Name: _____
Emergency contact's phone # (other than your own home #) _____
Relationship to client: _____

General Information

Occupation:

How many hours do you work each week?

How satisfied are you in your work?
Military: Yes or No
Branch _____
Dates of service _____ Branch _____
Rank _____
Type of discharge:

DAILY ROUTINE

How is your appetite? _____ Any changes in the last six months? _____
Recent weight loss or gain? _____

How well do you sleep? _____
Any changes in the last six months ____ Fall asleep OK? _____

Stay asleep? _____

Approximately how many hours of sleep do you get each night? _____

Describe your exercise habits?

MEDICAL:
Physician: _____
City _____ Date last seen: _____
Ongoing medical concerns: _____
Allergies: _____
Medication(s) _____

LEGAL:
Current _____ Previous _____ N/A _____
Charges _____ Probation? _____
Court district _____

EDUCATION:
Highest – grade achieved: _____

Name of College or Vocational school: _____
Year of Graduation _____

Relationships:

(If working with a couple, place their initials next to their responses)

Marital Status:
[ ] single, never married
[ ] engaged _____ months
[ ] married for _____ years
[ ] divorced for ____ years
[ ] separated for ____years
[ ] divorce in process ____ months
[ ] live-in for _____ years
[ ] ____ prior marriages (self)
[ ] ____ prior marriages (partner)

Intimate Relationship:
[ ] never been in a serious relationship
[ ] not currently in a relationship
[ ] currently in a serious relationship

Relationship Satisfaction:
[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very satisfied with relationship

On a scale of 1 to 10 with 10 being the greatest, please rate the quality for each the following:

	Quality of Communication	Emotional Intimacy	Level of Trust
Spouse			
Family			
Others			

Please explain why you rated each of the categories the way you did.

Children

Do you have children? If so, what are their names and ages?

Are any of them adopted? If so from where and at what age?

Do you have any step children? If so, from what marriage.

Faith Background/Denomination

Regarding spirituality or religion, how were you raised?

Present affiliation or name of church you attend?

What are your current religious beliefs?

How often do you participate in your faith community?

How satisfied are you in how you were religiously brought up?

How do you practice your faith?

If applicable: **Have your religious experiences and training helped or hurt your ability to deal with your struggles?**

If applicable: **Do you wish to incorporate your Christian faith in counseling sessions?**

The Basic Problem(s) as You Understand It

What is the most current issue or problem that is occurring in your life personally or in your family?

How does the problem affect you?

How does the problem make you feel physically?

How does the problem affect you emotionally and/or spiritually?

What goals do you wish to accomplish during our sessions together?

History of Problem

When did you first notice the problem?

Do you have any idea what led to the problem?

What event(s) in the recent past has prompted you to seek counseling now?

Check or highlight any recent losses you have experienced:

❑ Family ❑ Health ❑ Disruption of lifestyle ❑ Job ❑ Significant other ❑ Other, please describe

Methods/Treatments/Interventions

What have you tried to change, or alleviate the problem?

Have you ever gone to a counselor before?
If yes, when?

What seemed to have helped when you went to counseling previously?

Was there anything that did not help you when you were in counseling previously?

Family of Origin

What are your parent's names' and ages?

Were you adopted? If so, age?

If you were raised by anyone other than your parents, briefly explain

Are they still married?
If so, what is the state of their marriage like?

What is something that your parents did well?

What is something you wished your parents did better?

Describe your primary female care giver (mother, relative, step mother) as you remember her during your life at home. List some of her characteristics as a person.

Describe your primary male caregiver (father, relative, step father) as you remember him during your life at home. List some of his characteristics as a person.

Are you closer with your mom or dad?
Why or why not?
How would you describe your relationship with both of your parents?

How did your parents or caregivers get along with each other while you were in the home?

Check or highlight all descriptors that accurately characterize your childhood experience:

☐ Loving/Supportive	☐ Unstable	☐ Emotional Abuse
☐ Chaotic	☐ Parents Argued	☐ Verbal Abuse
☐ Stable	☐ Physical Abuse	☐ Sexual Abuse/ Rape

☐Molestation ☐Witnessed Violence ☐Rejected by Mother
☐Spiritual Abuse ☐Rejected by Father ☐Little Memory

Substance Use/ Mental Health History of Family: (X all that apply)

	Mother	Father	Sister	Brother	Children	Others
Alcoholism						
Amphetamines						
Cocaine						
Heroin/Opiates						
Marijuana						
Anxiety						
Depression/Mood Disorder						
Eating Disorder						
Schizophrenia						
Suicide Attempt						
Other						

List any other relatives with a history of emotional or mental disorder or suicide (include diagnosis and treatment if known):

Number of older: Brothers_____ Sisters_____

Number of younger: Brothers_____ Sisters_____

Names of Siblings:

Describe any significant relationship problems between you and your siblings:

Do you have any step family members? If so, whom?

If so, which are you closest to and why?

List any significant past trauma experienced by you or those close to you (i.e., death, divorce, sickness, crime, etc.)

As a child, how would you characterize your family's economic status?

❑**Wealthy** ❑**Middle Class** ❑ **Poor**

Personal Habits, Abuse, and Mental Illnesses

What are your hobbies?

What are your strengths?

What are your weaknesses?

Have you been diagnosed with a mental illness?

Which are you most like?

❑ Even-keeled ❑ Tend toward depression ❑ Up & down

Are you extroverted or introverted?

Have you ever been abused (verbally, emotionally, physically, sexually)? If so, when, where, and who did it? Age?

Substance Use History

Current Alcohol use: No ❑ Yes ❑ If yes, on average how many drinks per week? What kind of drink(s)?

Nicotine use: No ❑ Yes ❑ If yes, how much per day?

Caffeine use No ❑ Yes ❑ If yes, how much per day?

Marijuana use: No ❑ Yes ❑ If yes, how much per day?

Are you currently using any non-prescription drugs: No ❑ Yes ❑
If yes, how much per day/week?

Check all or highlight circumstances that apply to you regarding your use of drugs and/or alcohol:

❑ Used to sleep	❑ Morning Use	❑ To Get Rid of Hallucinations
❑ Used to Relax	❑ Used Alone	❑ Other
❑ Relieve Emotional Pain	❑ To Avoid Withdrawal	
❑ Relive Physical Pain	❑ To Function Socially	

Check all or highlight consequences you have experienced due to your use of drugs and/or alcohol:

❑Hangovers	❑Withdrawal Symptoms	❑Sleep Disturbances

❑Binges
❑Seizures
❑Medical Problems
❑Assaults
❑Loss of Job
❑Overdose
❑Legal Problems
❑Relationship Conflicts/Divorce
❑Suicidal Thoughts

Have you ever tried to reduce substance use including drinking? No ❑ Yes ❑

Have you ever been annoyed by other's comments about your substance use? No ❑ Yes ❑

Do you consider your drinking or drug use a problem?

Non-substance abuses compulsive behaviors?

❑ None ❑ Gambling ❑ Sex ❑ Pornography ❑ Shopping ❑ Eating ❑Excessive Electronic Use ❑ Other

***If yes,* please describe how you act out with these behaviors and how often:**

Pornography & Sexuality

Have you ever looked at pornography? If so, when, where, and how often?

What was your age when you first saw pornography?

Do you have any sexual struggles of any kind? If so, what?

Are you sexually active?

Have you ever been forced to carry out a sexual act(s) or have a sexual act(s) performed on you against your consent or will? If yes, age? And by whom?

Risk of Harm

(Please check or highlight all that apply)

❑ Is not a risk for harm
❑ Self injurious behavior
❑ Previous suicide attempts
❑ Social isolation
❑ Suicidal ideation (current)
❑ Suicidal plan
❑ Exposure to violence
❑ Insomnia
❑ Recent loss
❑ Hopelessness
❑ Feel like a burden

Functional Impairment

(Please check or highlight all that apply)

- ❑ **Avoiding friends/family**
- ❑ **Conflicts with spouse/partner**
- ❑ **Conflicts with family/friends**
- ❑ **Missing work/school**
- ❑ **Lower productivity**
- ❑ **Not enjoying normal activities**
- ❑ **Spending too much time alone**
- ❑ **Unemployment**
- ❑ **Legal problems**
- ❑ **Not taking medications as prescribed**

Symptoms

(Please check or highlight all that apply)

- ❑ **Depressed Mood**
- ❑ **Pressured speech**
- ❑ **Poor concentration**
- ❑ **Grandiosity**
- ❑ **Isolated**
- ❑ **Decreased need for sleep**
- ❑ **Weight loss/gain**
- ❑ **Distractibility**
- ❑ **Sleep disturbances**
- ❑ **Hyper-focused**
- ❑ **Fatigue**
- ❑ **Indiscretions**
- ❑ **Low Self-worth**
- ❑ **Delusions**
- ❑ **Suicidal Ideation**
- ❑ **Hallucinations**
- ❑ **Anxiety**
- ❑ **Disorganized speech**
- ❑ **Irritability**
- ❑ **Obsessions**
- ❑ **Muscle tension**
- ❑ **Compulsions**
- ❑ **Restlessness**
- ❑ **Flashbacks**
- ❑ **Panic**
- ❑ **Hypervigilance**
- ❑ **Chest Pain**
- ❑ **Intrusive distressing thoughts**
- ❑ **Sweating**
- ❑ **Attempts to avoid thoughts**
- ❑ **Trembling**
- ❑ **Recurrent alcohol use**
- ❑ **Chills**
- ❑ **Racing thoughts**
- ❑ **Short of Breath**
- ❑ **Numbness/Tingling**
- ❑ **Dizzy**

What Other Information Would You Like to Share That You Believe Would Be Helpful:

Thank you for answering these questions. Your information will be kept confidential and secure according to state laws and regulations.

ABIDING HOPE COUNSELING