

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:

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

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Do you have any hobbies or special interests?

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What do you do for relaxation and recreation?

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How do you cope with stress?

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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: \_\_\_\_\_

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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.)

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

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

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