WELL & BEYOND

CLIENT QUESTIONNAIRE - Confidential

Name of Client/Patient: ____

(Last) (First) (Initial)

Mailing Address: ____

(P.O. Box or Street) (City) (State) (Zip Code)

Telephone: ____________________/____________________/____________________

(Home) (Work) (Other)

Please indicate any precautions or restrictions for calls or messages at these phone numbers:

____

Date of Birth: ____________ Marital status: ______________

Household composition (family members and all others living in the home):

Last Name	First Name	Relationship	Age/DOB

In case of emergency, contact: ____

(Name) (Relationship to Client) (Telephone)

Health Insurance Information:

Complete only if you wish to use your health insurance for reimbursement of our services:

Insurance: ____

(Insurance Company Name) (Insurance Plan Name, if applicable)

Insurance: ____

(Address) (City) (State) (Zip) (Telephone)

Patient's Insurance ID Number: ________________ Policy Number: ______________

Group Number: ______________ Employer: ________________________

Subscriber: ____

(Name) (DOB) (Subscriber ID Number)

Subscriber: ____

(Address) (City) (State) (Zip) (Telephone)

Person(s) responsible for payment of counseling services:

____

(Name) (Address) (City) (State) (Zip) (Telephone)

____

(Name) (Address) (City) (State) (Zip) (Telephone)

Request for Fee Reduction:

In case of limited financial resources and lack of insurance coverage, clients may request a reduced fee. Reduced fees are based on a client's financial situation. If you would like to request a reduced fee, we will ask you to disclose the basics of your financial situation to your therapist, so that the adjustment to our regular fee appropriately reflects your ability to pay.

Check here _______ if you would like to request a fee reduction.

Referral Information

How did you find out about us?

- ☐ Health Care Provider (doctor, therapist)
- ☐ Other Professional (teacher, lawyer, clergy)
- ☐ Family, Friend, Co-worker
- ☐ Yellow Pages
- ☐ Printed Media (newspaper ads, article)
- ☐ Internet, Web Site
- ☐ Brochure
- ☐ Other: _________________________________

Did someone specifically refer you to us? ☐ Yes ☐ No

Name of the person who referred you: ____

May we have your permission to thank this person for the referral? ☐ Yes ☐ No

Personal Information

Racial Background: ______________________ Ethnic & Cultural Background: ______________________________

Sexual orientation: ☐ Heterosexual ☐ Gay/lesbian ☐ Bisexual ☐ Transgender

Education

Education: ____ Are you currently in school? ☐ Yes ☐ No

If yes, what school & program: ____

Do you plan to go back to school in the future? ☐ Yes ☐ No If yes, describe: ______________________

Work & Career

Are you currently employed? ☐ Yes ☐ No

If yes: Occupation: ___________________________________ Employer: _____________________________

Job Responsibilities: ____

Describe job satisfaction in current position? ____

If no : ☐ Self-employed ☐ Unemployed ☐ On medical/family leave, sabbatical

☐ Staying-at-home parent ☐ Other: ____

Describe significant jobs you have had in the past, if any: ____

____

Are there work or career goals you have not realized yet? Any interests/talents you would like to use more in your work? ____

____

Personal Interests

How do you spend your leisure time? ____

____

What hobbies or special interests do you have, or would like to develop? ______________________

____

Spiritual & Religious Background

Spiritual/religious/denominational preference: ______________________________________

Childhood religious background: ____

Current spiritual practices: ____

Explain recent changes in your spiritual life, if any: ________________________________

Explain any past important spiritual experiences: ___________________________________

____

Current Marriage/Relationship

If you are currently not married or in a significant relationship, check here _______ and skip this section.

When did you meet your partner/spouse? __________ When did your intimate relationship begin? _________

Are you and your spouse/partner currently living together? ☐ Yes ☐ No

If yes, since when? __________ If married, date of marriage: _______________

Current relationship status: ☐ Going steady ☐ Engaged ☐ Married ☐ Separated - temporary

☐ Separated - permanent ☐ In divorce proceedings ☐ Divorced ☐ Other: ___________________

Relationship satisfaction: ☐ Happy/content ☐ Average ☐ Unstable/up & down ☐ Unhappy

☐ Confused/ambivalent ☐ In crisis ☐ Consider leaving ☐ Other: ________________________

In your marriage/relationship, are/were there concerns about (check all that apply):

☐ Alcohol/substance abuse ☐ Money ☐ Sex/intimacy

☐ Abuse/domestic violence ☐ Trust/commitment ☐ Infidelity/affairs

☐ Parenting ☐ Physical/emotional health ☐ Frequent arguments

☐ Other: ____

When you and/or your partner are angry or have a conflict, does either of you ever (check all that apply):

☐ Scream or swear ☐ Push or shove ☐ Slap, punch, hit or kick

☐ Threaten ☐ Break or throw things ☐ Say insulting or derogatory things

Are there ever times when you are afraid of your partner? ☐ Yes ☐ No

If yes, explain: ____

What are strengths and positive aspects of your relationship? ______________________________

____

What part of your relationship is difficult or not working? ________________________________

____

Your spouse/partner:

Name: ________________________________ Age: _________ Education: __________________________

Occupation: ___________________________________ Spiritual background: ________________________

Racial/ethnic/cultural background: ____

Previously married/divorced? ☐ Yes ☐ No

If yes, dates of marriage & divorce: ____

Has your spouse/partner children from previous marriage/relationships? ☐ Yes ☐ No

If yes, indicate name, sex, age & living arrangements for each child: ________________________________

____

Previous Marriage(s) and Relationships

Were you previously married/divorced? ☐ Yes ☐ No

If yes, indicate name & age of previous spouse(s), dates of marriage(s) & divorce(s):

____

____

Please list significant, non-marital relationships, include name & age of partner(s) and timeframe of relationship(s):

____

____

____

Information About Children

Do you have children? ☐ Yes ☐ No If yes, list all your children:

Name	Age	Sex	Marital Status	Living where/with whom?

How do you get along with your children? ____

____

Are any of your children non-biological children? ☐ Yes ☐ No

If yes, explain: ____

Have you ever experienced abortion, infertility or pregnancy loss? ☐ Yes ☐ No

If yes, explain: ____

Would you like to have any children, or additional children? ☐ Yes ☐ No

If yes, explain: ____

If you have no children, indicate the reasons (check all that apply):

☐ Choice ☐ Infertility ☐ Live Circumstances: ____________________

☐ Other: ____________________

Family of Origin History

Were your parents divorced? ☐ Yes ☐ No If yes, how old were you at the time of divorce? ______

Were you raised by your biological parents? ☐ Yes ☐ No If no, raised by:

☐ One parent: _________ ☐ One parent & step-parent ☐ Relative(s): ____________________

☐ Adoptive parent(s) ☐ Forster parent(s) ☐ Other: ____________________

Answer this section, describing your parents or parent-substitute:

Date of birth (year)	Father: __________	Mother: __________
Still living? (yes or no)	Father: __________	Mother: __________
If deceased, when?	Father: __________	Mother: __________
If married, when?	Father: __________	Mother: __________
Ethnic/cultural background	Father: __________	Mother: __________
Religious/spiritual preference	Father: __________	Mother: __________
Education	Father: __________	Mother: __________
Occupation	Father: __________	Mother: __________

Briefly describe your relationship with each parent:

Father: ____________________

Mother: ____________________

List your brothers and sisters in birth order:

Name	Age	Sex	Marital Status	Living where/with whom?

In your family of origin (parents, siblings) is there a past or current presence of:

Alcohol or substance abuse:	☐ Yes	☐ No	If yes, explain: __________
Mental illness/emotional problems:	☐ Yes	☐ No	If yes, explain: __________
Chronic physical illness/disability:	☐ Yes	☐ No	If yes, explain: __________
Abuse (verbal, physical, sexual):	☐ Yes	☐ No	If yes, explain: __________
Frequent family conflict, outbursts	☐ Yes	☐ No	If yes, explain: __________

Please describe aspects of your family of origin that seem important (for example: parents' relationship; relationship(s) with your sibling(s); your role in the family; family atmosphere; family rules; how you complied with or rebelled against family expectations).

____

____

____

____

Physical Health

Physician

Are you currently under a doctor's care? ☐ Yes ☐ No Date of your last physical exam: __________

Physician's Name: ____ Telephone: ______________________

Do you give permission to communicate with your primary care physician (for coordination of your treatment, and for exchange of relevant medical and mental health information)?

☐ Yes ☐ No

Other Health Care Providers

Are there currently other health care providers (physician, nurse practitioner, physical therapist, naturopath, chiropractor, acupuncturist, nutritionist, massage therapist etc.) involved in your health care?

☐ Yes ☐ No

If yes, please describe: ____

Medications

Are you currently taking any medication? ☐ Yes ☐ No

If yes - Medication Name: ________________________________ Dosage: __________________

Prescribed by: _________________________Taken for: _________________________________

Health Information

How would you rate your current physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any injuries, disabilities, chronic pains or illnesses? ☐ Yes ☐ No

If yes, explain: ____

____

Do you have any current physical problems? ☐ Yes ☐ No

If yes, describe: ____

____

What is your height? _______________ What is your current weight? ________________

Did your weight change recently? ☐ Yes ☐ No If yes: Lost __________ Gained ___________

Do you restrict your eating or diet in any way? ☐ Yes ☐ No

If yes, how and why? ____

Do you exercise? ____

Use of Substances

Check if you are using or have used any of the following:

- ☐ Alcohol
- ☐ Anesthetics (Pain Killers, Nitrous Oxide)
- ☐ Barbiturates (Sleeping Pills)
- ☐ Caffeine (Coffee, Coke, Chocolate, Energy Drinks)
- ☐ Hallucinogens/Psychedelics (LSD, Mushrooms, Peyote, Mescaline, MDMA/Ecstasy)
- ☐ Marijuana
- ☐ Narcotics (Opium, Morphine, Heroin)
- ☐ Solvents & Inhalants (Glue, Gasoline); Deliriants; PCP
- ☐ Stimulants (Cocaine, Crack, Amphetamines, "Speed" Pills)
- ☐ Tobacco Nicotine
- ☐ Tranquilizers (Valium, Librium)
- ☐ Prescription or Over-the-Counter Drugs (for non-medical use)
- ☐ Other Drugs

For any substance category checked above, describe:

Substance Name	Date: First Use	Date: Last Use	Using Now?	Amount/Day	How often?

Self-description of substance use:

- ☐ Not using substances
- ☐ Rare/infrequent use of substances
- ☐ Recreational use/social drinker
- ☐ Frequent use/heavy drinker
- ☐ Have drug/drinking problem
- ☐ Addict/alcoholic
- ☐ Other: ____

Have you ever been in substance abuse treatment? ☐ Yes ☐ No

If yes, please describe: ____

Have your ever attended a self-help group? ☐ Yes ☐ No

If yes, please check: ☐ AA/NA ☐ Al-Anon ☐ Other Self-Help Group: ____________________

Behavioral Health

Have you ever been in psychotherapy or counseling? ☐ Yes ☐ No

If yes: When? ______________________ For how long? ______________________

For what? ______________________ With whom? ______________________

Type of therapy: ______________________ Results: ______________________

Have you ever been treated by a psychiatrist? ☐ Yes ☐ No

If yes, describe: ____

Have you ever taken medications for psychiatric or emotional problems? ☐ Yes ☐ No

If yes, describe: ____

Have you ever been hospitalized for psychiatric or emotional problems? ☐ Yes ☐ No

If yes, describe: ____

Have you ever been suicidal? ☐ Yes ☐ No

If yes, describe: ____

Indicate and date any significant, disruptive events in your life, such as illnesses, accidents, relocations, losses, deaths, trauma or violence: ____

____

____

Checklist of Concerns

Please check all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues" You may add a note or details in the space next to the concerns checked.

- ☐ Aggression, violence, threats, abusive behavior, loss of control
- ☐ Alcohol and/or drug use
- ☐ Anger, irritability, temper, outbursts, arguing
- ☐ Anxiety, fears, worries, nervousness, phobias
- ☐ Assertiveness
- ☐ Attention, concentration, distractibility
- ☐ Avoidance, procrastination
- ☐ Decision-making, indecision, putting off decisions, ambivalence
- ☐ Dependence, co-dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Discrimination, harassment, unfair treatment by others
- ☐ Education, school problems
- ☐ Excessive, addictive behavior (gambling, work, sex, computer/internet use, electronic games)
- ☐ Finances, money

- ☐ Headaches, physical tension, other aches and pains
- ☐ Health problem, physical symptoms, illnesses
- ☐ Intrusive thoughts, nightmares
- ☐ Legal matters, charges
- ☐ Life meaning and purpose, emptiness
- ☐ Loneliness, isolation, withdrawal
- ☐ Loss, grieving, separation, divorce
- ☐ Low energy, tiredness, fatigue
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Obsessions, compulsions
- ☐ Panic or anxiety attacks
- ☐ Parenting, children, step-children
- ☐ Past, unresolved events (childhood or other)
- ☐ Relationships: parents, family, in-laws
- ☐ Relationships: spouse, intimate partner
- ☐ Relationships: friend(s)
- ☐ Self-confidence, self-esteem
- ☐ Self-mutilation
- ☐ Sexual issues (poor sex, desire differences, dysfunctions)
- ☐ Sleep difficulties
- ☐ Spirituality, religion
- ☐ Stress, tension
- ☐ Suicidal thoughts/feelings
- ☐ Trauma/abuse
- ☐ Trust
- ☐ Unhappiness
- ☐ Weight & diet issues (overeating, undereating, appetite, vomiting, body image)
- ☐ Work problems, employment, career choices

Any other concerns or issues:

- ☐ ____
- ☐ ____

Please look back over the concerns you have checked off, and choose the ones that you would like to address in counseling:

1. ________________________ 2. ________________________

3. ________________________ 4. ________________________

5. ________________________ 6. ________________________

Why are you seeking counseling at this time? ____

____

____

____

What are your goals for therapy? What do you want to accomplish?

____

____

____

____

______________________________	______________________________	______________
Person filling out this form - print name	Signature	Date