CLIENT QUESTIONNAIRE

GENERAL INFORMATION

Name: ______________________________ Date: ____________________

Address: ____

Work Phone: ____________ Cell Phone: ____________ May I Leave Msgs? Yes / No

E-mail: ____

Date of Birth: ____________ Age: _____ Marital Status: ____________________

Occupation: ____________________ Education Level: ____________________

Names and Ages of children: ____

____

Vehicle Information Make: ____________ Model: ____________ Color: ________

Driver's License #: ________________ License Plate: ____________________

Referral Source: ____

FINANCIAL INFORMATION

Annual Household Income: ________________ Do you own or rent?: ____________

How do you intend to pay for treatment? (cash, check, charge, insurance): ____________

If planning to use health insurance:

Name of Insurance Company: ______________________________________

Policy Number: ______________ Group Number: ____________________

Telephone Number: ____

AREAS OF CONCERN

What issue(s)/concern(s) cause(s) you to seek treatment? Please describe. ____________

____

____

____

What do you hope to gain from sessions? _________________________________

____

____

Do you have any particular concerns/ fears with regard to treatment? ____________________________

____

____

____

What is your interpretation of therapy? ____

____

____

PSYCHOLOGICAL HISTORY

Have you ever received mental health treatment before? ____________________________________

When and for how long? ____

What was the focus of treatment? ____

Name of previous treating therapist: ____

Address: ____ Phone: _____________

Have you ever been subjected to one or more psychological tests? _____________________________

If so, by whom? ____

Name of person(s) who administered psychological tests: ________________________________

Address: ____ Phone: _____________

Have you ever been hospitalized for mental or emotional problems? ____________________________

Hospital Name and Location: ____

When and for how long? ____

Why were you hospitalized? ____

Are you currently taking any prescription medications? Yes / No If so, please list: _____________

____

Prescribed by whom?: ____

How long have you been on the medication(s)?: ____

Have you ever taken any medications for a mental or emotional condition? Yes / No

When and for how long?: ____

Have you ever attempted suicide? ____

When? ______________________ Describe the circumstances that led to that attempt:

____

____

Are you currently having any suicidal thoughts? Please describe: ___________________

____

____

Please describe your childhood: ____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe:

____

____

Have you ever been a victim of a violent crime? Please describe: ___________________

____

____

MEDICAL HISTORY

Have you ever been diagnosed with a serious illness? Please describe: _______________

____

____

Do you have any medical conditions that may affect your mental health treatment? Yes / No

Please describe your overall health today: ______________________________________

____

Are you experiencing medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe: ______________________________________

____

Have you ever been in a 12-step program? Please describe: _______________________

____

Do you smoke? ________ How much? _______________ For how long? ____________

Do you drink alcohol? ____

On average, how much alcohol do you consume in a week? _______________________

Have you ever used illegal drugs? Please describe. ______________________________

____

FAMILY OF ORIGIN HISTORY

Mother's name, age, living/decreased, client's age at the time of mother's death, description of relationship with mother. ______________________________

____

____

Father's name, age, living/deceased, client's age at the time of father's death, description of relationship with father. ______________________________

____

____

Names and ages of siblings: ______________________________

____

____

OTHER INFORMATION

Please describe your spiritual identity/orientation: ______________________________

Please describe your interests/hobbies: ______________________________

____

Are you now or have you ever been involved in a lawsuit? ______________________________

Please describe: ______________________________

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested: ______________________________

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Limits of Patient Confidentiality

I, Ruth Lynch, LMFT, greatly respect your right of privacy, especially regarding information you share in psychotherapy. I also believe you should fully understand the limitations of confidentiality in order for you to make an informed decision regarding what you disclose in therapy. Some of the limits of patient confidentiality are listed below and I may be required to disclose confidential information if any of the following conditions exist:

Initial: _________ You are a danger to yourself or others.

Initial: _________ You waive your rights to privileges or give consent to limited disclosure by your therapist.

Initial: _________ You file suit against your therapist for breach of a duty or if your therapist files suit against you.

Consent to Treatment

Initial: _________ I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist and that the treatment may not work, changes may be disruptive, and the process may be emotionally unsettling.

Initial: _________ I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. For example, if my treatment has been court-ordered, I will have to answer to the court.

Initial: _________ As an alternative to therapy there are available recovery and support groups, self help programs, and books.

Initial: _________ I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. I understand there may be cases of illness but I need to call in a timely manner. If I do not cancel or do not show up, I will be charged for that appointment.

Financial Agreement

Initial: _________ I understand that scheduled appointments are reserved for me. I will notify the therapist as soon as possible if I am unable to attend my session. I may be billed a NO SHOW or Cancelled appointment fee if appropriate.

I hereby assume full responsibility for any bills incurred in this office. I understand that payment of said bills is not contingent upon any insurance coverage I might have or obtain.

Signature: ____ Date: ____________________________

Print Name: ____