THERAPEUTIC SERVICES AGENCY, INC.

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CLIENT INFORMATION QUESTIONNAIRE

Name_____ Today's Date_____

Address_____
(Street) (City) (State) (Zip)

Phone (Home)_____ (Work)_____

If necessary, can you be called at home? Yes_____ No_____ At Work? Yes_____ No _____

If no at home and work, how can you be reached_____

Race_____ Date of Birth_____ M_____ F_____ Age_____

If Under 18, Parent or Guardians Name _____

Address_____
(City) (State) (Zip code)

In case of emergency, call: _____ _____ _____
(Name) (Phone) (Relationship)

We wish to facilitate service delivery to best meet your needs. Please advise staff of your need for handicap accessible meeting space, linguistic or other communication factors, such as reading skill, hearing or speech impairment considerations.

_____

Referred here by_____

Please note reasons or recent difficulties that led you to seek our services:

_____

_____

FAMILY INFORMATION

Marital Status: Single___ Married___ Separated___ Divorced___ Widowed___ Single with live-in partner___

Your Occupation_____

Do you attend School?_____ Grade_____ Name of School_____

Is spouse or other family members willing to come for counseling if needed? Yes___ No___ Uncertain___

Do you have children?_____ Ages?_____ Do they live with you?_____

Who lives in your family household?_____

Describe your childhood?

Were you ever abused (physical, sexual, emotional)?

Who do you rely on for emotional support?

Have there been major losses, changes or crisis in your life? *If yes, please describe :*

PHYSICAL HEALTH

Have you or any one in your family had any of the following? *(please check)*

	You	Family Member		You	Family Member
Tuberculosis	____	____	High Blood Pressure	____	____
Alzheimer's	____	____	Blood Clots or Stroke	____	____
Diabetes	____	____	Heart Attack, Heart Disease	____	____
Cancer	____	____	Chemical Dependency	____	____
Mental Illness	____	____	Thyroid Problems	____	____
Epilepsy/Seizure	____	____	Family History Unknown	____	____

If you answered with a check to any of the above, please explain:

_____

_____

Your Physician's Clinic _____ Phone_____ Date of last physical exam_____

Clinic Address_____
City State

How would you rate your physical health? Excellent_____ Good_____ Fair_____ Poor_____

Do you have any physical health concerns currently?

_____

Are you presently taking medications? Yes_____ No_____ If yes, what and why? _____

_____

List all <u>important</u> present illnesses, past illnesses, injuries, and/or disabilities:_____

_____

Do you have any allergies?_____ If so what are they?_____

MENTAL HEALTH

Symptom Checklist: *(Please check any symptoms you are experiencing)*

____Aggression/Anger Outbursts	____Eating Disorders	____Irritability	____Alcohol Abuse
____Elevated Mood	____Loneliness	____Anxiety	____Fatigue
____Memory Problems	____Avoidance of People	____Gambling	____Mood Swings
____Chest Pains	____Hallucinations	____Muscle Tension	____Computer Addiction
____Headaches	____Panic Attacks	____Depression	____Helplessness
____Racing Thoughts	____Difficulty Concentration	____Hopelessness	____Restlessness/On Edge
____Distractibility	____Impulsivity	____Sexual Addiction	____Dizziness
____Indecisiveness	____Sexual Difficulties	____Drug Abuse	____Sleeping Problems
____Stressed Out	____Trembling	____Weight Gain/Loss	____Withdrawal
____Relationship Problems	____Worrying	____Worthlessness	____Fears (List) Other_____

PAST HISTORY OF MENTAL HEALTH PROBLEMS/TREATMENT:
Include therapy, hospitalizations, medications, & their effectiveness.

What was the outcome? Positive_____ Not much change_____ Negative_____

FAMILY HISTORY OF MENTAL HEALTH PROBLEMS

Do you currently use psychotropic medication? _____ Please name the medication(s)_____

_____ _____ _____ _____

Who prescribed them? _____

Current Stressors: *(Please check all that apply)*

____Marital Conflict	____Poor Peer Relations	____Legal Problems	____Separation/Divorce
____Problems at Work	____Health Problems	____Conflict with Children	____Job Loss or Change
____Recent Death	____Conflict with Siblings	____Problems at School	____Substance Abuse
____Conflict with Parents	____Financial Problems	____Housing Problems	____Recent Move
____Physical Abuse	____ Parenting Problems	____Sexual Abuse	____Emotional Abuse
____Conflict with Other Family	____Other (List):_____		

CHEMICAL HEALTH

Substance Use: (Please indicate both current and past use)

	Current Use		*Past Use*				
Substance	Yes	No	Yes	No	Amount Used	Frequency	Date Last Used
Tobacco	___	___	___	___	_____	_____	_____
Caffeine	___	___	___	___	_____	_____	_____
Alcohol	___	___	___	___	_____	_____	_____
Marijuana	___	___	___	___	_____	_____	_____
Cocaine/Crack	___	___	___	___	_____	_____	_____
Methamphetamines	___	___	___	___	_____	_____	_____
Heroin	___	___	___	___	_____	_____	_____
Amphetamines	___	___	___	___	_____	_____	_____
LSD	___	___	___	___	_____	_____	
Ecstasy	___	___	___	___	_____	_____	_____
Inhalants	___	___	___	___	_____	_____	_____
IV Drug Use	___	___	___	___	_____	_____	_____

Please list Prescription Drugs (current and past)

_____ _____

_____ _____

_____ _____

List any use of herbal supplements or over the counter medications:_____

_____

PAST HISTORY OF SUBSTANCE ABUSE TREATMENT: *(Include AA/NA, counseling, hospitalization, and residential re).*

HIGH RISK FACTORS- SUICIDE CONCERN

	Past	Now
Have you ever had thoughts of committing suicide?	____	____
Have you ever had a plan to commit suicide?	____	____
Have you made threats to kill yourself?	____	____
Have you ever made a suicide attempt?	____	____
Have you ever mutilated yourself?	____	____
Have you ever had plans to harm someone?	____	____
Have you ever attempted to harm someone?	____	____
Have you made threats to harm someone?	____	____
Do you do high-risk activities when emotionally distressed?	____	____

LIFESTYLE

Please circle the correct answer to the following questions

Yes No Have you ever had or wonder if you have an alcohol or drug problem?

Yes No Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?

Yes No Is religion or spirituality an important part of you life? Religious/Church affiliation_____

Yes No Are you employed? Type of work_____Weekly schedule (days, nights, # of hours) _____

Yes No Do you go to school?

Yes No Do you have weapons? Please explain_____

Yes No Are there professionals involved in your life at this time? Who and for what purpose?

_____

Yes No Do you have financial stressors? Low_____ Moderate_____ High_____

Yes No Are there other persons living in your home other than immediate family members?

Yes No Have you ever been arrested or had other legal problems? Please note_____

_____

How long have you been struggling with the issues you wish to discuss with your counselor? _____

How many hours of sleep do you get per night/day? _____ What recreation or hobbies do you enjoy? _____

What personal strengths do you have or what personal qualities do you like about yourself?

_____

Any other information you wish to share with the professional who will be meeting with you?

_____

_____ _____

Your Signature Date