Infinite Hope
COUNSELING

Client Questionnaire

INSTRUCTIONS: *Please answer these questions to help assist the clinician in understanding the client's needs and concerns. When the clinician agrees to treat a couple or a family, the couple or family is considered to be the client. For the purpose of this form, you must choose who the "client" will be. Usually, it is the individual covered by insurance, if you have insurance coverage.*

Please check the category below that best matches the client's treatment request.

☐ Individual Adult Issues
☐ Child/Adolescent Issues
☐ Couple/Marriage Issues
☐ Family Issues

CLIENT INFORMATION

Client's Name: (Last) _____ (First) _____ (MI) ____

Client's Address:_____ City:_____ State:_____ Zip:_____

Client's DOB: _____ Gender: Female ☐ Male ☐ SS#: _____ Marital Status: _____

Cell #: _____ Home #: _____ Work #: _____

Email: _____

COMMUNICATION AUTHORIZATION

OK to send mail?	Yes ☐	No ☐	OK to send email?	Yes ☐	No ☐
OK to call cell?	Yes ☐	No ☐	OK to leave voicemail message on cell?	Yes ☐	No ☐
OK to call home?	Yes ☐	No ☐	OK to leave voicemail message at home?	Yes ☐	No ☐
OK to call work?	Yes ☐	No ☐	OK to leave voicemail message at work?	Yes ☐	No ☐
OK to text cell?	Yes ☐	No ☐			

PARTNER OR PARENT/LEGAL GUARDIAN INFORMATION

If minor is in state custody, the state representative must complete the appropriate questions within this section.

N/A ☐

Name: (Last) _____ (First) _____ (MI) ____

Address:_____ City:_____ State:_____ Zip:_____

DOB:_____ Gender: Female ☐ Male ☐ SS#: _____ Marital Status: _____

Cell #: _____ Home #: _____ Work #: _____

Email: _____

Relationship: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify*_____

EMERGENCY CONTACT

Name: (Last) _____ (First) _____ (MI) ____ ☐ Release Signed?

Cell #: _____ Home #: _____ Work #: _____

Relationship: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify*_____

PRIMARY CARE PROVIDER

Name: _____ ☐ Release Signed?

Agency: _____

Address:_____ City:_____ State:_____ Zip:_____

Office #: _____ Fax #: _____

OTHER PARTICIPATING FAMILY MEMBERS

N/A ☐

Name	Relationship to Client	Date of Birth	
_____	_____	_____	☐ Release Signed?
_____	_____	_____	☐ Release Signed?
_____	_____	_____	☐ Release Signed?

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PRESENTING PROBLEM

What is client's current reason for seeking therapy?

Please check all that are areas of concern for the client:

- ☐ Anger Management Problems
- ☐ Anxiety, Stress, and/or Panic
- ☐ Attachment Problems
- ☐ Behavior Problems
- ☐ Depression
- ☐ Domestic Violence
- ☐ Eating Problems
- ☐ Grief & Loss
- ☐ Irritability
- ☐ Low Self-Esteem
- ☐ Medical Issues
- ☐ Memory Problems
- ☐ Mood Problems
- ☐ Obsessions and/or Compulsions
- ☐ Parenting
- ☐ Relationship Concerns
- ☐ Sexual Concerns
- ☐ Sleep Difficulties
- ☐ Social Problems
- ☐ Substance Use
- ☐ Suicidal/Homicidal Thoughts
- ☐ Trauma
- ☐ Other _____

Is the client experiencing any suicidal and/or homicidal thoughts at this time? No ☐ Yes ☐
Does the client have any previous suicide attempts, self-destructive behaviors, or violent behaviors? No ☐ Yes ☐

MEDICATION INFORMATION

Are you taking any medication for anxiety, depression, or stress? No ☐ Yes ☐ *If yes, identify the medication and dosage below:*

STRESSORS

In the last 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered	Bothered a little	Bothered a lot
Worrying about your health	☐	☐	☐
Your weight or how you look	☐	☐	☐
Little or no sexual desire or pleasure during sex	☐	☐	☐
Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐
The stress of taking care of children, parents, or other family members	☐	☐	☐
Stress at work outside of the home or at school	☐	☐	☐
Financial problems or worries	☐	☐	☐
Having no one to turn to when you have a problem	☐	☐	☐
Something bad that happened recently	☐	☐	☐
Thinking or dreaming about something terrible that happened to you in the past —like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

In the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? No ☐ Yes ☐

What is the most stressful thing in your life right now? _____

I attest that the information provided in or attached to this questionnaire is complete, accurate, and true to the best of my knowledge.

_____ _____
Client Signature or Parent/Legal Guardian Signature *(mandatory if client is a minor)* Date