Psychotherapy Client Questionnaire

Name: _____ Date: _____

REFERRED BY:

Name: _____ Phone#: _____

Address: _____

May I inform this person that you have consulted with me? _____

_____
Your Signature

CONFIDENTIALITY STATEMENT:

State law and professional ethics require therapists to maintain confidentiality except for the following situations:

1. If there is suspected child abuse, elder abuse, or dependent adult abuse.

2. "Tarasoff" and “Ewing” situations in which serious threat to a reasonably well- identified victim is communicated to the therapist.

3. When threat to injure or kill oneself is communicated to the therapist. Therapist may use discretion to decide if confidentiality must be broken.

4. If you are required to sign a release of medical records by your medical insurance.

5. You may be required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. **Think carefully and consult with an attorney before you sign away your rights.**

6. Clients being seen in couple, family, and group work are obligated to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in your treatment process. Secrets may or may not be kept by the therapist from others involved in your treatment process.

7. I may at times consult with professional colleagues about our work without asking permission, but your identity will be disguised.

8. My personal secretary and private practice group members have access to locked and coded records but are legally charged with confidentiality.

9. Clients under 18 do not have full confidentiality from their parents.

10. It is also important to be aware of other potential limits to confidentiality that include the following:
• All records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances.
• Most records are stored in locked files but some are stored in secured electronic devices.
• Cell phones, portable phones, faxes, and e-mails are used on some occasions.
• All electronic communication compromises your confidentiality.

1. GENERAL

A. Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Fax: _____ E-Mail: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

B. What is your present living situation? ________

_____

C. Names and ages of children

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

D. Give a short history of your closest interpersonal relationships:

_____

_____

_____

_____

Education: _____

Occupation: _____

Currently working: _____

What is your present job situation? _____

_____

2. PROBLEM AREA

A. State in your own words the nature and history of your chief complaint:

_____

_____

_____

B. Present interests, hobbies, activities:_____

_____

C. How is most of your free time occupied?

_____

_____

D. What are your life goals?

_____

_____

_____

E. What are your five greatest fears?

1._____

2._____

3._____

4._____

5._____

3. FAMILY HISTORY

A. Father's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

_____

Your age at time of father's death: _____

Give a description of your father's personality:

_____

_____

_____

_____

B. Mother's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

_____

Your age at time of mother's death: _____

Give a description of your mother's personality:

_____

_____

_____

_____

C. Brothers/Sisters (Names, sex, age, and something about each):

[Are there significant others from your growing up years?]

_____

_____

_____

_____

D. Who are the most important people in your life? Describe.

_____

_____

_____

Previous Medical, Psychiatric, and Psychotherapy Contacts

E. Have you ever been in psychotherapy before?_____

If yes, when? _____

May I contact your previous therapist(s)? _____

Therapist:_____

Address: _____

Phone: _____

Therapist: _____

Address:_____

Phone: _____

F. Have you ever been hospitalized for an emotional problem?

If yes, when, where, and how long?_____

_____

If yes, when, where, and how long?_____

_____

G. Have you ever made a suicide attempt? If yes, describe it, when, and the circumstances leading up to the attempt.

_____

_____

H. Have any close relatives been treated for psychiatric problems?

If yes, please specify:_____

_____

I. Has any relative of yours committed suicide?

If yes, please specify:_____

_____

J. Give details of all forms of abuse you were subject to in childhood (neglect, verbal violence, sexual).

_____

_____

_____

_____

_____

K. Give a brief history of any litigation you have been involved in regarding child custody, divorce, liability, or medical malpractice.

_____

_____

_____

_____

_____

_____

4. SELF-DESCRIPTION

Give a word-picture of yourself. Describe yourself in terms of how you presently feel and see yourself (include both negatives and positives):

_____

_____

_____

_____

_____

5. MEDICAL HISTORY

A. Have you had any of these childhood illnesses?

	NO	**YES**	**DON'T KNOW**
Measles	___	___	_____
Mumps	___	___	_____
Whooping cough	___	___	_____
Chicken pox	___	___	_____
Rheumatic fever	___	___	_____
Rubella (German measles)	___	___	_____

Please list all medical hospitalizations and operations. Give diagnoses and dates:

_____

_____

B. Have you ever suffered from any of the following illnesses?

	NO	YES	DATE OF ONSET
Cancer	___	___	_____
TB	___	___	_____
Diabetes	___	___	_____
Thyroid trouble	___	___	_____
Kidney trouble	___	___	_____
High blood pressure	___	___	_____
Eye trouble	___	___	_____
Heart trouble	___	___	_____
Neurological disease	___	___	_____
Ulcers	___	___	_____
Head injury	___	___	_____
D.T.'s	___	___	_____
Allergies	___	___	_____

List all allergies: _____

_____

Any other serious illnesses? _____

C. Family History

Have any of your blood relatives suffered from any of the illnesses listed above? If yes, please specify ailment and relative:

_____

_____

Any other serious illness? _____

D. Drug/Medication History

Because many drugs (legal and illegal) have psychological effects, it is important for me to know what drugs you are *currently* taking and/or *have taken in the past*. This information will remain strictly confidential, but it is very important for me to know before you begin therapy so that an accurate assessment of your problem and situation can be made. Please list *all* legally prescribed and illegal drugs ever used (past or present) and describe how often you use them and what effects you seek:

_____

_____

_____

_____

Have any of these drugs been prescribed by a physician?

Yes _____ No _____ If so, which drugs and for what reason?

_____

E. Nutrition

Is your diet unusual in any way? Yes _____ No _____

If so, how? _____

_____

F. Symptoms

Check any of the following symptoms that apply to you at this time. Also indicate when any of these symptoms have applied to you in the past.

Hair falling out	_____	Fainting spells	_____
Weight gain	_____	Difficulty sleeping	_____
Fatigue	_____	Drinking too much fluid	_____
Constipation	_____	Blurred vision	_____

Dry skin	_____	Deafness	_____
Weakness	_____	Ringing in ears	_____
Weight loss	_____	Chest pain	_____
Tremor	_____	Shortness of breath	_____
Big appetite	_____	Tingling of hands or feet	_____
Fast heart beat	_____	Ankle swelling	_____
Diarrhea	_____	Indigestion	_____
Poor appetite	_____	Nausea or vomiting	_____
Headaches	_____	Urinary difficulties	_____
Dizziness	_____	Problems with sexual organs	_____

G. Menstrual History, Issues, or Problems:_____

_____

_____

_____

H. Smoking and Drinking

Do you smoke (anything)? _____ What? _____How much? _____ Frequency? _____

Do you drink alcohol? _____ If yes, how much? _____

What happens to you when you smoke or drink, that is, what does it do for you?

_____

_____

Describe any physical symptoms at all that you have when you smoke or drink.

I. What kind, and how much physical exercise do you get?

_____

_____

J. Describe the spiritual/religious aspects of your life:

_____

_____

K. Have you ever been hypnotized? If so, for what and what were the results?

_____

_____

_____

L. Have you ever been on worker's comp or disability? For what, how long, results?

_____

_____

_____

M. In case of emergency, please notify one of the following three people: May I have your permission to inform one or all of these people if you are ever in danger?

Yes _____ No _____

1. _____
Name Daytime Phone Evening Phone Address

2. _____
Name Daytime Phone Evening Phone Address

3. _____
Name Daytime Phone Evening Phone Address

This questionnaire supplements previous informed consents.

_____ _____
Your Signature Date

_____ _____
Your Signature Date