Rebecca Johnson, LMFT #79769
1010 Sir Francis Drake Blvd. Suite 101, Kentfield, CA 94904
(415) 820-1612

CLIENT QUESTIONNAIRE

Client Information

Client Name: _____ Nickname or Preferred Name: _____

Age: _____ Date of Birth: _____/_____/_____ Race: _____

Home Address: _____

Home Phone: _____ ok to leave message? Yes No

Cell Phone: _____ ok to leave message? Yes No

Email Address: _____ ok to leave message? Yes No

Occupation: _____ Education Completed: _____

Marital status: ☐ Married ☐ Remarried ☐ Divorced ☐ Separated ☐ Widowed
☐ Single ☐ Cohabitants

If married, how long have you been married? _____

If divorced, how long have you been divorced? _____

Please list any children:

Name: _____ Age: _____ ☐ Son ☐Daughter

Name: _____ Age: _____ ☐ Son ☐Daughter

Name: _____ Age: _____ ☐ Son ☐Daughter

Name: _____ Age: _____ ☐ Son ☐Daughter

Please List Additional People Living in the Home:

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

In Case of Emergency, Please Call:

Name: _____ Relationship: _____ Phone#:_____

Name: _____ Relationship: _____ Phone#:_____

How were you referred? _____

Why You're Here:

1. Describe the main reasons you are seeking assistance: _____

   _____

   _____

   _____

   _____

   _____

   _____

2. How have you been dealing with these issues so far? _____

   _____

   _____

3. How do you hope I can be of help? _____

   _____

   _____

4. What do you think is a realistic time frame for solving your problem?_____

   _____

5. Do you have any particular concerns or fears regarding therapy? _____

   _____

Symptoms and Behaviors:

Please indicate if any of the following symptoms/problems/complaints affect you. Enter (0) for none, (1) mild, (2) moderate, or (3) severe. Add comments as desired.

	Abuse/trauma history		Afraid to leave house
	Alcohol and/or drugs causing problems at work or home		Angry outbursts
	Anxiety/nervousness		Appetite increase/decrease
	Avoidance of social/work obligations		Binging/purging
	Black out from drinking		Body image issues
	Confused/not thinking clearly		Cries easily
	Depressed/sad mood		Difficulty completing projects
	Difficulty concentrating/mind going blank		Distrust
	Dizzy/light-headed/faint		Domestic violence
	Dramatic emotional highs/lows		Drinking in morning
	Everything is an effort		Family problems/conflict
	Fatigue/decrease in energy		Fear/worry
	Fear of losing control/going crazy		Feeling keyed up, on edge
	Feeling overwhelmed by the tasks of living		Feelings of worthlessness/guilt
	Few friends		Flashbacks

	Forgetful		Frequent stomachaches/headaches/other pains
	Gambling		Grief/loss
	Heart-pounding/palpitations		Hear voices that others don't hear
	Hopelessness		Hyperactive/agitated/restless
	Illness (self, others)		Impulsive, loss of control
	Inability to recall aspects of an upsetting event		Inattentive/distractible
	Indecision		Intake of 4 or more drinks within two hours
	Intense fear of gaining weight		Intrusive thoughts, compulsive behaviors
	Irritable, easily annoyed		Lack clarity re: purpose/values
	Legal issues		Loneliness/isolation
	Lose track of time		Loss of interest in usual activities
	Low self-esteem		Muscle tension
	Nightmares		Over eat/under eat
	Over exercise		Panic attacks
	Phobias		Poor social skills
	Recent move/other major changes		Restless, fidgety
	Relationship problems		Religious or spiritual issues
	Risky behaviors (including sexual)		See things that others don't
	Self-harming behaviors/cutting		Sense of reliving a past upsetting event
	Sense of unreality/detachment from self		Sexual problems
	Sexual identity issues		Shy/social fears
	Startle easily		Stress
	Suicidal thoughts		Suicide attempts
	Thoughts of hurting others		Thoughts that others want to hurt or discredit you
	Trembling, twitching or feeling shaky		Trouble falling, staying asleep
	Trouble getting "stuck" on certain thoughts		Tics/involuntary movements
	Unpleasant thoughts		Weight changes

Psychological History:

1. Have you ever had any previous psychotherapy or psychiatric treatment? ☐ No ☐ Yes If yes, why, where, how long, and did you feel it was helpful? _____

   _____

   _____

   _____

   Previous therapist(s)/practitioner(s): _____ Date of Last Visit: _____

2. Are you currently taking or have you ever been prescribed medication for a mental or emotional condition? ☐ No ☐ Yes If yes, please list: _____

   _____

   Psychiatrist Name and Number: _____ Date of Last Visit: _____

3. Have you ever been hospitalized for a mental or emotional condition? ☐ No ☐ Yes If yes, when and for how long, resolution? _____

_____

4. Have you attempted suicide? ☐ No ☐ Yes If yes, when and what were the circumstances?

_____

_____

6. Are you currently having suicidal thoughts? ☐ No ☐ Yes If yes, please describe: _____

_____

_____

7. Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes
   If yes, please describe:_____

_____

8. Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ No ☐ Yes
   If yes, please describe:_____

_____

9. Have you ever been subjected to physical, emotional, or sexual abuse or assault, been a victim of a violent crime or other traumatic event? _____

_____

_____

<u>Physical Health</u>:

1. How would you rate your current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific health problems you are currently experiencing: _____

_____

2. Have you ever been diagnosed with a serious illness? ☐ No ☐ Yes If yes, please describe:

_____

3. Are you currently experiencing chronic pain? ☐ No ☐ Yes If yes, please describe: _____

_____

4. How would you rate your current sleeping habits? (please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific sleep problems you are currently experiencing. _____

_____

5. How many times per week do you generally exercise? (please circle)

   0 1-2 3-4 5+

   What types of exercise do you participate in? _____

6. How many meals do you eat a day? _____

   Please list any difficulties you experience with your appetite or eating patterns: _____

   _____

7. Do you drink alcohol? (Please circle) Never 1-2 times/week 3 or more/week
8. How often do you engage in recreational drug use? (Please circle)

   Daily Weekly Monthly Infrequently Never
9. Have you ever been in a 12 step program? ☐ No ☐ Yes If yes, please list: _____

   _____

10. Medications

All Prescribed Medications	Purpose	Dose	Side Effects

Physician Name and Number: _____ Date of Last Physical: _____

Family of Origin History:

Mother's Name: _____ Age: _____ Living/Deceased, Age at time of Mother's death _____ Description of relationship with mother: _____

_____

_____

Father's Name: _____ Age: _____ Living/Deceased, Age at time of Father's death _____ Description of relationship with father: _____

_____

_____

Siblings:

Name: _____ Age: _____ Describe Relationship: _____

Name: _____ Age: _____ Describe Relationship: _____

Name: _____ Age: _____ Describe Relationship: _____

Name: _____ Age: _____ Describe Relationship: _____

Family Mental Health History:

In the section below identify if there is a family member who is currently or in the past has experienced any of the following.

	Circle	Circle	List Family Member
Alcohol/Substance Abuse	Yes/No	Past/Current	_____
Anxiety	Yes/No	Past/Current	_____
Depression	Yes/No	Past/Current	_____
Suicide Attempts	Yes/No	Past/Current	_____
Domestic Violence	Yes/No	Past/Current	_____
Child Abuse	Yes/No	Past/Current	_____
Eating Disorders	Yes/No	Past/Current	_____
Obesity	Yes/No	Past/Current	_____
Schizophrenia	Yes/No	Past/Current	_____
Other (please describe)	_____		

Lifestyle Information

1. Stress in your life

	Please Circle	Describe
Financial difficulties	Yes/No	_____
Family/relationship difficulties	Yes/No	_____
Job/Work stress	Yes/No	_____
Other: _____		

2. Are you currently in a romantic relationship? ☐ No ☐ Yes If yes, for how long? _____
   On a scale of 1-10 (with 10 being extremely satisfying) how would rate your relationship? _____

3. Are you employed? ☐ No ☐ Yes If yes, what is your current employment situation: _____
   _____
   Do you enjoy your work? Is there anything stressful about your current work? _____
   _____

4. What significant life changes or stressful events have you experienced recently:
   _____
   _____
   _____

5. Available Support (please check boxes that apply)

	Excellent	Good	Fair	Poor	N/A
Family					
Neighbors/community					
Friends					
Co-workers					
Pets					

Strengths

1. What do you consider to be some of your strengths? _____

   _____

   _____

   _____

2. What are your interests/hobbies? _____

   _____

   _____

   _____

3. What are your family's strengths? _____

   _____

   _____

   _____

4. Describe any cultural, ethnic, or spiritual identification or affiliations that are important to you or your family._____

   _____

   _____

Anything else that may be important to know about _____

_____

_____

_____

_____

_____

On a scale of 1-10, with 1 being the worst you've ever felt in your life, circle the number that applies TODAY:

(Worst I've ever felt) 1 2 3 4 5 6 7 8 9 10 (Best I've ever felt)