Client Questionnaire

Please fill out this biographical background form as completely as possible. It will help me in our work together. All information is confidential as outlined in the informed consent form.

Name:_____ Today's date:_____

Address:_____City:_____Zip:_____

Date of Birth: _____ Age: _____

Telephone: H: _____W: _____Cell: _____

May I leave a message? If so, on which number? _____

E-mail:_____ May I e-mail you?_____
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation:_____Employer/School:_____

Emergency Contact: _____Phone:_____

Do I have your permission to contact this person in an emergency? Yes_____ No _____

Medical Doctor/s (Name/Phone): _____

Referred by: _____

Education: _____Current Marital Status: _____

If married, # of years_____ If divorced, # of years_____ Spouse/partner_____

Children (Names/Ages)_____

Do you have a history of self destructive or violent behaviors? _____

Are you currently taking any prescription medication (please list names, dosage, condition, prescriber)?

_____

_____

Is there a family history of any of the following?

	(Please Check)		(Family Member)
Alcohol Abuse:	□ yes	□ no	_____
Substance Abuse:	□ yes	□ no	_____
Depression:	□ yes	□ no	_____
Suicide Attempts:	□ yes	□ no	_____
Bipolar Disorder:	□ yes	□ no	_____
Schizophrenia:	□ yes	□ no	_____
Eating Disorders:	□ yes	□ no	_____

Please add any additional information that may be helpful to our work together _____

_____

_____