



CLIENT THERAPEUTIC QUESTIONNAIRE

Please fill out this form and bring it to your first session along with Intake Information.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years old)

(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age: ____ Gender: Male Female _____

General and Mental Health Information

1. What has brought you into therapy at this time? (i.e., significant life changes, stressful events)

2. List any previously received mental health services (psychotherapy, psychiatric services, etc.)

3. List any prescription medications you are currently taking.

4. Have you ever been prescribed psychiatric medication? Yes No

Please list and provides dates: _____

5. How would you rate the following using the scale below?

1-Poor 2-Unsatisfactory 3-Satisfactory 4-Good 5-Very good

If applicable, list any specific problems you are currently experiencing next to your rating:

a. Physical health: _____

b. Sleep habits: _____

c. Eating habits: _____

d. Exercise habits: _____

What types of exercises do you participate in? _____

General and Mental Health Information (continued)

6. Do you experience any chronic pain? What parts of the body?

7. Substance Use

- a. Do you drink alcohol more than once per week? Yes No
- b. Do you currently or have you in the past smoked cigarettes or cigars? Yes No
- c. Do you currently or have you in the past engaged in recreational drugs? Yes No

8. On a scale from 1–10 with 1 being most functional without symptoms and 10 being least functional with many symptoms. Where would you rate the following emotions:
(If applicable, also describe your symptoms in each area (emotional, physical, sensations, thoughts))

- a. Depression, sadness, grief, no motivation _____
- b. Anxiety, nervousness, panic, phobias, worry _____
- c. Anger, frustration, irritability, stressed _____
- d. Other: _____

Relationships

9. Are you currently in a romantic relationship? Yes No

If yes, for how long: _____
Rate your relationship on a scale of 1–10, with 1 being very poor to 10 being excellent: _____

10. Do you have close friendships? Do you feel connected to others?

11. How are you involved in your community? If not, what would you like to do to become more involved?

Work / School Information

12. a. Are you currently employed or attending school? Yes No
If yes, what is your current employment or academic situation:

b. Do you enjoy work / school? Is there anything stressful about it?

Family Mental Health History

13. In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

	Please Check	List Family Member
Alcohol/Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Obsessive Compulsive Behavior	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Personality Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Suicide Attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Foundational Beliefs System

14. a. Do you consider yourself to be spiritual? Yes No Unsure

If yes, describe your belief (love of nature, mindfulness, mind-body, higher power, law of attraction):

14 b. Do you consider yourself to be religious? Yes No Unsure

If yes, describe your faith (Attends church, following a certain faith, prayer):

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

16. What do you consider to be some of your weaknesses?

Goals/Coping Methods

17. What would you like to accomplish in therapy? What would you like to work on?

18. What have you tried on your own to address your goals? (i.e., coping methods) What has worked or not?

Additional Information

19. Include any important information you would like to share with your therapist that was not asked on this form. You can also note to ask you about prior or current traumatic events that may be difficult for you to write out on this form. We are here to help you and together work toward your healing.
