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INDIVIDUAL CLIENT INFORMATION QUESTIONNAIRE

Your cooperation in completing this will be helping in planning services for you. Please answer each item carefully or ask your therapist for clarification should you have any questions.

Date: _____

Patient's Name: _____

Date of Birth:_____ **Patient's SSN:**_____

Address:

_____
street ***city*** ***state zip***

Marital Status:_____ **Education:**_____

Employment: _____

Phone Numbers:	***Ok to call?***	***Ok to leave message?***
Home: _____	*yes/no*	*yes/no*
Work: _____	*yes/no*	*yes/no*
Cell: _____	*yes/no*	*yes/no*

Regarding minors: The party who brings the minor child for appointments is the responsible party for billing unless special arrangements are made with our Office.

Parent Name: _____ *DOB:*_____

SSN: _____

Address: _____
street *city* *zip*

Employer: _____ *Phone*: _____

Briefly describe your reasons for seeking help:_____

_____

Who suggested you call us? _____

List any major health problems and all medications you are currently taking:

_____

_____

_____

Have you ever received mental health treatment before? Yes/No

If Yes, please explain: _____

_____

List all the members of your family and any others living in your home:

NAMES	***RELATIONSHIP***	***AGE***	***OCCUPATION***

Please check any of the problems which apply to you:

___anxious	**___stressed**	**___depressed**
___relationship conflict	**___work/school**	**___finances**
___attention/concentration	**___making decisions**	**___behavior**
___relationship conflict	**___anger**	**___impulsivity**
___health problems	**___pain**	**___sleep problems**
___memory	**___appetite**	**___weight**
___parenting	**___alcohol use**	**___drug use**
___harm self	**___suicidal thoughts**	

Please review the Outpatient Services sheets on the next page & sign at end.

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