Anna Hamrell, LCSW

New Client Questionnaire

Personal Information:

Name: ______________________________________Gender: _________Date:_________________________

Age:___________

Date of Birth: _________________

Phone(Cell/Work) ____________________________ (Home)____

May I contact you and leave messages at one or both of these phone numbers? _____Yes _____No

Address:____City:___________________________________

State: ________ Zip:___________ Email: ____

May I email you? _____Yes _____No

Emergency Contact __________________________________ Phone: _______________________________

Emergency Contact's Relationship to You: ______________________________

Medical Doctor(s) (name/phone):____

Occupation: ___________________________________ Employer:_________________________________

How long have you worked there?: ________________ How long in this occupation?___________________

How did you hear about me?:____

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

Education:

What is the highest level of education you have attained? ____

Are you currently in school? _________ Yes ________ No

If you are in college, what are you studying? ____

If you have not yet completed high school, what grade are you in now? ________________________________

Reason for Seeking Therapy (be as specific as you can: when did it start, how does it affect you in your life/work/relationship)

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____

Have you been in therapy before? If so, when and on what issues did you focus? Whom did you see?

____

____

____

What are your main worries and fears?

____

____

What do you identify as your strengths?

____

____

What do you identify as your weaknesses?

____

____

Please check if there has been any recent changes in the following:

Sleep patterns	Weight
Physical activity level	Focus
Eating patterns	Energy level
General disposition	Nervousness/Tension
Behavior	Other (specify)________________

Describe changes in areas in which you checked above:

____

What would you like to focus on in therapy?

____

____

____

Assuming that you achieved your goals for coming to therapy, what would some of your gains look like?

____

____

____

Relationship Information:

Current Marital Status:_______________ Do you live with someone:______

Name:____ #Years:_____

Past & Present Marriage(s) (years together, names and statement about the nature of the relationship(s) i.e., friendly, distant, physically/emotionally abusive, loving, etc.) ___________________________________

____

____

____

____

Present Spouse/Partner: Education:_______________________ Occupation:________________________

Children/Step/Grand: (name/ages and brief statement on your relationship with the person)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Parent/Step Parent: (name/age or year of death/cause of death, occupation, personality, how did they treat you, brief statement about the relationship):

Father: ____

____

Mother: ____

____

Step Parents: ____

____

If Parents Divorced: Your age at the time:_____

Describe how it affected you at the time:____

____

Siblings: (name/age, if dead: age and cause of death and brief statement about the relationship):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Describe your childhood in general (relationships parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

____

____

____

____

Family Medical and Psychiatric History:

Describe any physical or mental illnesses that run in the family including depression or suicide:

____

____

Describe any abuse of substances that runs in the family:

____

____

Describe any history of violence or emotional/physical abuse:

____

____

Past/Present Psychotherapy: Please specify the month year(s) (beginning-end), estimated number of sessions, name and degree of therapist, initial reason for therapy, individual/couple/family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. ____

   ____

2. ____

   ____

3. ____

   ____

Have you ever experienced the following:

	Yes	No	When	Where	Your reaction to overall to experience
Therapy/Counseling	___	___	__________	____________	______________________
Suicidal Thoughts/Attempts	___	___	__________	____________	______________________
Drug/Alcohol Treatment	___	___	__________	____________	______________________
Hospitalizations	___	___	__________	____________	______________________

If you have experienced suicidal thoughts/suicide attempt(s) or any other violent behavior, please describe (described: ages, reasons, circumstances, how etc.):

____

____

Please check behaviors and symptoms occur to you more often than you would like them to take place:

Aggression	Elevated mood	Phobias/fears
Alcohol dependence	Fatigue	Recurring thoughts
Anger	Gambling	Sexual addiction
Antisocial behavior	Hallucinations	Sexual difficulties
Anxiety	Heart palpitations	Sick often
Avoiding people	High blood pressure	Sleeping problems
Chest pain	Hopelessness	Speech problems
Cyber addiction	Impulsivity	Suicidal thoughts
Depression	Irritability	Disorganized thoughts
Disorientation	Judgment errors	Trembling
Distractibility	Loneliness	Withdrawing
Dizziness	Memory impairment	Worrying
Drug dependence	Mood shifts	Other
Eating disorder	Panic attacks	

Briefly discuss how the above symptoms impair your ability to function effectively:________________________

____

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____

____

____

____

Medical/Physical Information:

Past/Present Medical Care (major medical problems, surgeries, accidents, falls, illness-please include dates):

____

____

____

Are you taking any medication(s) at this time?

____

Prescription Drugs:

Type	Amount	Frequency	Date Last Used

Past/Present Drug/Alcohol Use/Abuse (AA, NA, treatments):

____

____

Coffee (#______ cups/daily)

Cigarettes (#______ per day)

Alcohol (#______ drinks/daily______ or weekly______) Date last drank:__________________

Street Drugs:

(Type):____________________ Frequency:________ Age of First Use_____Date of Last Use_________

(Type):____________________ Frequency:________ Age of First Use_____Date of Last Use_________

(Type):____________________ Frequency:________ Age of First Use_____Date of Last Use_________

(Type):____________________ Frequency:________ Age of First Use_____Date of Last Use_________

Substance of preference:____

Describe when you typically use substances:____

Describe any changes in your use patterns:____

Reasons for use:

Addicted
Build confidence
Escape
Self-Medication
Socialization
Taste
Other

Does/has someone in your family present/past have/had a problem with drugs or alcohol? ___Yes ___No

If yes, describe:____

Have you had adverse reactions or overdosed drugs or alcohol?

(Describe):____

Any past or current legal issues with substances? (DUI, DWI etc.) ___Yes ___No

If yes, describe:____

List any current health concerns:____

List any recent health or physical changes:____

Social Relationships:

Check how you generally get along with other people: (check all that apply)

__Affectionate	__Aggressive	__Avoidant	__Fight/Argue Often
__Friendly	__Follower	__Leader	__Outgoing
__Shy/Withdrawn	__Submissive	__Other (specify)_________________	

Any concerns about social relationships? (Specify)

____

____

Leisure/Recreational:

Describe special areas of interest or hobbies (e.g. art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling etc.)

Activity	How often now?	How often in the past?

Friendships, Community, and Spirituality (describe quality, frequency, activities, etc.):

____

____

____

What gives you most joy or pleasure in your life?

____

____

____