NEW CLIENT QUESTIONNAIRE

Welcome to Complete Connections Couples Counseling Center! Thank you for taking a few minutes to fill out this form. The information you provide is confidential, and will be helpful for you and your counselor when you meet for the first time. If you have any questions, please ask.

Today's Date_____

Name _____ Age _____
Date of Birth _____/_____/_____
Address _____

Phone (Primary) _____ (Secondary)_____
Email (please print clearly) __

Ethnicity_____ Where did you grow up? _____
Education _____ Occupation _____
What is you religious background / involvement
_____
Emergency contact person (name, relationship, phone, address).
_____
Closest Relationships (please list name, birth date, relationship, and whether they live with you)

Name	Birth Date	Relationship	Living with you?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your current living arrangement
_____
Have you participated in any therapy before? Y___N___ If yes, when? _____
Reason _____
Are you currently seeing a psychiatrist or therapist? Y____ N___
Have you or a family member ever been hospitalized for mental or emotional illness? Y____ N_____
If yes, please explain—dates, where, reason:
_____

Substance abuse / addiction history? No _____ Yes (please explain) _____
_____
Legal History (arrests, prison, DWI, parking tickets?)
_____
Medical Information: Doctor's name and phone
_____
Are you on any medications? Y___N___ If so, what and why?
_____

Please tell us in your own words what brings you here today?
_____
_____

_____

What are your 2 most important goals for therapy?

1. _____
2. _____

Common problem/symptom checklist. Fill in: 0 - none, 1 - mild, 2 - moderate, 3 - severe.

___marriage ___divorce/separation ___alcohol/drugs ___God/faith
___pre-marital ___child custody ___other addictions ___church/ministry
___being single ___disabled ___grief/loss ___past hurts
___sexual issues ___work/career ___depression ___codependency
___family ___school/learning ___fear/anxiety ___emotional intimacy
___children ___money/budgeting ___anger control ___communication
___parents ___aging/dependency ___loneliness ___self-esteem
___in-laws ___weight control ___mood swings ___stress control

Family Information:

Marital Status (check any that apply): Single ___ Dating ___ Committed relationship ___ Engaged ___ Married (how long? _____) Separated ___ (how long? _____) Divorced ___ (how long?_____)

Spouse's Name (if applicable) _____ Age _____

Occupation _____

I would describe my friendships as: Close ___ Somewhat close____ Distant____ Conflicted____

I would describe my relationship with my mother as: Close ___ Somewhat close____ Distant____ Conflicted____

I would describe my relationship with my father as: Close ___ Somewhat close____ Distant____ Conflicted____

How many siblings do you have? _____ How would you describe your relationship?

_____

Crisis Information: Are you having any current suicidal thoughts, feelings or actions? Y____ N_____

If yes, explain _____

Any current homicidal or violent thoughts or feelings, or anger-control problems? Y_____ N_____

If yes, explain _____

Any issues, hospitalizations, or imprisonments for suicidal or assault behavior? Y_____ N_____ If yes, describe _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Y____ N___

If yes, describe

_____

Who referred you to this office? _____

THANK YOU for taking the time to fill out this information sheet. This will be reviewed with you during your first counseling appointment.