Concepts of Truth, Inc. Client Information Form Questionnaire

CLIENT INFORMATION

This questionnaire asks for personal information that may illicit feelings of discomfort. Reveal details as you feel comfortable and if answering these questions is more difficult than you anticipated, please let me know. It is not uncommon to feel a bit uneasy after revealing such private information to someone. Submitting this form means that you have also read and agreed to the Informed Consent.

Today's Date: Last Name:

First Name: Middle Initial:

Nickname: Marital Status:

U.S. Driver's License State and Number:

Birth Date: Age:

Other Official Identification (passport, State I.D., etc):

Street Address: P.O. Box:

City:

State: Country:

ZIP Code:

Home Phone:

Email address:

Your occupation:

Employer:

Can we leave a message on your home phone?

Can we leave a message on other phone? If yes, other phone no.:

EAP Name or other Referral Source

REQUESTED SERVICE INFORMATION

What counseling service(s) is requested at this time? Are you interested in traditional face-to-face counseling, distance counseling or a combination of both? Face-to-face counseling depends on your location and my availability.

For distance counseling, what is your preferred method of communication?

What concern has prompted you to contact me at this time?

Client Information Form Questionnaire Pg. 2   Client Name:

REQUESTED SERVICE INFORMATION CONT.

If you are requesting distance services, why are you interested in distance counseling rather than traditional face-to-face counseling at this point?

Please check all that you have experience with:

Email__   Instant Messaging/Chat __ Encrypted email or chat__ Videoconferencing__

Blogs__ Chat rooms with multiple people__ Bulletin Boards/Forums__ Payment for items / services online__ Texting (mobile device)__ Social networks like Facebook or Twitter__ Gaming__ Second Life / Virtual Worlds__

Are you using a PC Mac Mobile Device? (not all encrypted counseling services are compatible with mobile devices)

What type of platform does your computer use?

If other, what type?   What type of internet access do you have?

IN CASE OF EMERGENCY

Who should be contacted in case of emergency?

Relationship to patient: Home Phone: Work Phone:

INTAKE / BACKGROUND INFORMATION

Have you ever been in treatment with a therapist or counselor in the past?

If so, when were you treated and for what problem(s)?

What was the result of this treatment?

Are you being treated by a therapist, counselor, or psychiatrist now?

Are you experiencing any negative feelings or “symptoms” at this time, e.g. feeling anxious, depressed, sad, angry, frustrated, etc?

How severe would you say your symptoms are?

What have you already tried for this problem?

Have you tried anything that DOES help?

Are you currently taking any psychotropic medication (e.g., anti-depressants or anti-anxiety medication)?

If so, what type of doctor prescribed it?

Client Information Form Questionnaire Pg. 3   Client Name:

INTAKE / BACKGROUND INFORMATION Cont.

Have you taken any psychotropic medication in the past?

Please list all medications you are now taking, including the dosage. Please include prescriptions, over-the-counter, herbal, homeopathic medications and nutritional supplements.

How often do you drink alcoholic beverages?

How often do you use recreational drugs?

Please list below all recreational drugs you use.

Have you ever been hospitalized for drug or alcohol abuse, a suicide attempt, “nerves” or other mental health Concern? If so, please give dates and circumstances:

How many hours a day do you spend on your computer or mobile device?

Is the majority of this time work related?

Do you feel your technology use is balanced and healthy or could it be improved?

Do you have any other concerns about finding balance in your life with issues such as exercise, gambling, sexual activity, food?

If you are married or have a "significant other" or long-term partner, how long have you been together?

Do you have any children?   If so, what are their names and ages?

Name   Age

# of Pregnancies ?   # of Miscarriages?   # of Abortions?

Who lives in the household with you?

Name   Relationship

Do you have any brothers or sisters?   If so, where are you in the sibling order?

Where do your siblings live and how do you get along with them?

Are your parents alive?   How do you get along with them?

Do you have in-laws?   How do you get along with them?

How much education have you completed?

If you are a student now, please complete the following questions:

Which school do you attend?   How are your grades?   How do you like school?

Client Information Form Questionnaire Pg. 4   Client Name:

INTAKE / BACKGROUND INFORMATION CONT.

If you are in college or graduate school, what is your major?

Are you happy with your current job/career?   If not, why?
What jobs/careers have you done in the past and how did you like them?

How many times have you moved in the past year?

How is your overall health?   Do you have any medical problems now or in the past that would be helpful for me to know?

Have you ever been arrested or convicted of a crime?

It would be helpful to know about your family of origin, what your childhood was like, and anything else about what your family and life were like when you were growing up.

Were you ever physically or sexually abused as a child?

If yes, by whom?

Have you ever felt in the past like harming yourself or somebody else?

Do you have those feelings now?

Is there anything else about you that I should know such as ethnicity, gender preference or sexual identity?

(Form adapted from www. onlinetherapyinstitute.com)