Psychotherapy Client Questionnaire

Larry Christensen, Psy.D.
2520 NW Upshur St.,
Portland, OR 97210
503-358-0923

Name: ____ Date: ______________
Last First MI

Address: ____
Street or Box Number City State Zip Code

____________________ ____________________ ____________________
HOME PHONE WORK PHONE CELL OR MESSAGE PHONE

Are there any restrictions calling or leaving a message? ☐ - Yes ☐ - No
What restrictions? ____
Referred by? ____

Gender: ☐ - Male ☐ - Female
Sexual Orientation: ☐ - Heterosexual ☐ - Gay/Lesbian ☐ - Bisexual

Race: ☐ - Caucasian ☐ - African American ☐ - Hispanic ☐ - American Indian
☐ - Asian American ☐ - Multiracial ☐ - Other ____________________

Age: _________ Birth date: _____/____/_____ Social Security # ____________________

IN CASE OF EMERGENCY CONTACT: ____________________________________
HOME PHONE: ____________________ ***WORK PHONE:*** ____________________

Current Problem/difficulty

Briefly describe the specifics of your problem(s): ______________________________
____
____
____
____
____
____

What do you want to accomplish as a result of your psychotherapy? ____________________
____
____
____
____

Relationship Status: ☐ - Committed Relationship ☐ - Legally Married ☐ - Single
☐ - Divorced ☐ - Separated ☐ - Partner Deceased
☐ - Other ______________________________

Do you have a supportive network of friends and/or family ☐ - Yes ☐ - No ☐ - Unclear

EMPLOYMENT HISTORY ☐ - Full time (35 + hours) ☐ - Part-time (17-34 hours)
☐ - Irregular (Less than 17 hrs) ☐ - Not employed

Occupation: ______________________________ Place of Employment: _________________________
Employer's Address: ____
Length of Employment: ________________ years.

EDUCATIONAL HISTORY
Highest Grade Completed? __________________ Enrolled in School now? ☐ - Yes ☐ - No
How did you do in school? ☐ - Good ☐ - Fair ☐ - Poor

FAMILY HISTORY
Father's name: ____ Age: ____________
If deceased, age and cause of death: ____
Your age at time of father's death: _________ Did your father abuse drugs or alcohol? ☐ - Yes ☐ - No
Please describe your relationship with your father: ____
____
____

Mother's name: ____ Age: ____________
If deceased, age and cause of death: ____
Your age at time of Mother's death: _________ Did your mother abuse drugs or alcohol? ☐ - Yes ☐ - No
Please describe your relationship with your mother:____
____
____

Do you have any children? (oldest first)

Full Name	Birth date	Gender	At Home?
________________________________	_______________	☐- M ☐ - F	☐ - Yes ☐ - No
________________________________	_______________	☐- M ☐ - F	☐ - Yes ☐ - No
________________________________	_______________	☐- M ☐ - F	☐ - Yes ☐ - No
________________________________	_______________	☐- M ☐ - F	☐ - Yes ☐ - No
________________________________	_______________	☐- M ☐ - F	☐ - Yes ☐ - No

Please list your siblings (oldest first)

Full Name	Birth date	Gender	Still Living ?
________________________________	_______________	☐- M ☐ - F	☐ - Yes ☐ - No
________________________________	_______________	☐- M ☐ - F	☐ - Yes ☐ - No
________________________________	_______________	☐- M ☐ - F	☐ - Yes ☐ - No
________________________________	_______________	☐- M ☐ - F	☐ - Yes ☐ - No
________________________________	_______________	☐- M ☐ - F	☐ - Yes ☐ - No

CURRENT PROBLEMS AND SYMPTOMS

Please indicate the degree to which the following items are a problem to you in the past two weeks by placing the appropriate number next to the problem.

1 – No Difficulty 2 – Mild Difficulty 3 – Great Difficulty 4 – Overwhelmed

_____ Job _____ School _____ Alcohol _____ Partner/Relationship
_____ Financial _____ Family _____ Drug Use _____ Sexual Activity

(Rate each problem 1-4 and CIRCLE all words in parenthesis that pertain to you)

_____ **Anxiety** (Worry, fear, scared feelings, excessive guilt)
_____ **Depression** (unhappiness, hopelessness, lack of motivation, loss of enjoyment, poor concentration)
_____ **Thinking** (poor concentration, procrastination, poor memory, intrusive thoughts, obsessive thoughts)
_____ **Physical Symptoms** (pain, headaches, fatigue, stomach aches)
_____ **Self Control** (uncontrolled anger, overpowering sexual desires, compulsive/addictive behavior)
_____ **Emotions** (change quickly, hard to control, control to much)
_____ **Relationships with others** (friend, co-worker, partner)
_____ **Sleep** (difficulty falling asleep, difficulty staying asleep, sleeping too little, too much)
_____ **Appetite/Eating** (lack of appetite, recent weight gain, recent weight loss)

HARM TO SELF AND/OR OTHERS

Please check the category that best describes you present and past thinking and/or behavior related to harm to self and/or others. If you have a past history of harm to self and/or others please provide an approximate date (month/year).

HARM TO SELF (Check all that apply)	In Past 2 weeks	Before Past 2 weeks	Date
No thoughts of harm to self--	☐	☐	_______________
Thoughts (thoughts about or considering ideas about harming self)	☐	☐	_______________
Plan (plans as to how, when or where you might harm yourself)	☐	☐	_______________
Action (attempt or action to harm yourself) -------------------------------	☐	☐	_______________

HARM TO OTHERS (Check all that apply)	In Past 2 weeks	Before Past 2 weeks	Date
No thoughts of harm to others---	☐	☐	_______________
Thoughts (thoughts about or considering ideas about harming others)	☐	☐	_______________
Plan (plans as to how, when or where you might harm others)	☐	☐	_______________
Action (attempt or action to harm others) ----------------------------------	☐	☐	_______________

PAST PSCYHIATRIC OR PSYCHOTHERAPY HISTORY: Briefly state your prior experience with psychotherapy, psychiatric hospitalization, drug or alcohol treatment. ___________________________

____
____
____
____
____
____

MEDICAL HISTORY AND INFORMATION

How would you describe you health? ☐ - Excellent ☐ - Good ☐ - Fair ☐ - Poor

Name of your physician: ____

Address: ____

Telephone: ___________________________________

Are you currently being treated by him or her? ☐ - Yes ☐ - No

If yes, for what are you being treated? Please list medications and dosages: ___________________________

____

____

____

Other significant medical history or problems? ____

____

____

HISTORY OF ALCOHOL AND DRUG USE AND/OR PROBLEMS

Do you use alcohol? ☐ - Yes ☐ - No If yes, what kind and how much do you use?

Type: ____

Amount: ____

Frequency: ____

Do you use prescription or street drugs to get high? ☐ - Yes ☐ - No If yes, what drugs do you use?

Type: ____

Amount: ____

Frequency: ____

Have you ever been arrested for alcohol or drug related problems (e.g. driving while under the influence)?

☐ - Yes ☐ - No If Yes, please describe: ____

____

LEGAL HISTORY

Have you ever been arrested or involved in court proceedings? ☐ - Yes ☐ - No If Yes, please describe:

____

____

____