FABLED COUNSELING

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CLIENT QUESTIONNAIRE

The purpose of this questionnaire is to get a more complete picture of your personal, family and marital background without having to use a great deal of valuable therapy time. Please answer the questions as accurately as you can and feel free to ask any questions you have regarding the questionnaire.

Today's Date: ______________________________

NAME:______________________________ AGE:______________________

ADDRESS:____________________________ Date of Birth________________

____

____

PHONE NUMBERS:__________________HOME__________________WORK

Can I call you at home?___________ at work? ________

OCCUPATION:____

PLACE OF WORK:____

EDUCATIONAL LEVEL (Please indicate highest grade completed):

6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

CHILDREN:_____________(yes)________________(no)

(If yes) NAMES and AGES:____

____

____

____

Live with you: FULL TIME___________PART TIME___________

WHO REFERRED YOU?____

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1. Are you on any medication: (Please check one) YES_______NO_______

   IF YES, Please list NAMES OF MEDICATION, DOSAGE AND FREQUENCY TAKEN:

   ____

2. What is the general condition of your health?__________________________________

   When was your last medical checkup?__________

   Physician's Name and Phone Number: ____

3. HAVE YOU EVER GIVEN SERIOUS CONSIDERATION TO, OR ATTEMPTED TO, END YOUR OWN LIFE?
YES_______NO_______IF YES, please describe:

4. In case of emergency please contact:
   NAME:________________________________PHONE:______________________________

5. IS THERE A HISTORY IN YOUR FAMILY OF ANY OF THE FOLLOWING? Check all that apply:

sexual abuse______	physical abuse______
emotional abuse______	rape______
alcoholism/drugs_____	violence______
sleep disorders ______	eating disorder_____

   physical conditions______if so, what kind?____
   mental Illness______if so, what kind? ____

6. CHECK ALL OF THE FOLLOWING AREAS WHICH HAVE BEEN OR ARE A PROBLEM FOR YOU:

Marriage/Partner	□ Yes | □ No	Family	□ Yes | □ No
Job/School	□ Yes | □ No	Health	□ Yes | □ No
Finances	□ Yes | □ No	Legal	□ Yes | □ No
Friendships	□ Yes | □ No	Mood	□ Yes | □ No
Anxiety Level	□ Yes | □ No	Eating habits	□ Yes | □ No
Spirituality	□ Yes | □ No	Anger	□ Yes | □ No
Alcohol	□ Yes | □ No	Drug(s)	□ Yes | □ No
Sexual Difficulties	□ Yes | □ No	Caffeine	□ Yes | □ No
Smoking	□ Yes | □ No		
Ability to control your temper	□ Yes | □ No		

7. **HAVE YOU EVER RECEIVED COUNSELLING BEFORE** (*Please Check One)* □ Yes | □ No

If yes, please list type, length of time, and approximate dates:

8. HOW DID YOU FEEL ABOUT THE OUTCOME?

9. Briefly describe your reasons for counseling now:

10. Is there anything I have not asked you that is important for me to know?