PALM SPRINGS THERAPY

Client Questionnaire

Client Name: ____ Date of Birth: ____________
Last First Initial

Address: ____ Phone: ____________
Street City State Zip

Occupation: ____
Position Basic Description of Responsibilities

Current employment: ❒ none ❒ full time ❒ part time ❒ student ❒ disabled ❒ retired ❒ other: ________

Civil status: ❒ single ❒ married ❒ separated ❒ divorced ❒ partnership ❒ widowed ❒ other: ________

Highest grade of school completed: ____________ Place of birth: ____________________

Primary doctor's name: ______________________ Date of last physical: ____________

Insurance Company/Plan: ____

Primary language: ❒ English ____________ Secondary language: ❒ None ____________

How did you hear of Palm Springs Therapy?: ____

Please describe/briefly explain your main problem. Was there an event that prompted you to seek help now?:

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When did you first notice any signs or symptoms related to this problem?: ____________________

____

Check the behaviors and problems that apply to you currently or in the last year in the first column, labeled '*R*' for Recent. If they have occurred more than a year ago, check the second column, labeled '*P*' for Past:

R	P		R	P		R	P	
❒	❒	Anxiety	❒	❒	Feeling hopeless	❒	❒	Talking excessively
❒	❒	Depression	❒	❒	Fatigue/loss of energy	❒	❒	Restlessness/agitation
❒	❒	Grief	❒	❒	Feelings of worthlessness/guilt	❒	❒	Panic attacks
❒	❒	Anger	❒	❒	Feelings of inadequacy	❒	❒	Dizziness
❒	❒	Loneliness	❒	❒	Difficulty concentrating	❒	❒	Shortness of breath
❒	❒	Memory problems/changes	❒	❒	Difficulty making decisions	❒	❒	Chest pain
❒	❒	Domestic abuse	❒	❒	Indecisiveness	❒	❒	Numbness
❒	❒	Childhood abuse	❒	❒	Withdrawing/social isolation	❒	❒	Phobias/fears: ____________
❒	❒	Suicidal thoughts	❒	❒	Lose temper easily or explode	❒	❒	Fear of dying/death
❒	❒	Violent thoughts	❒	❒	Start fights or arguments	❒	❒	Obsessions
❒	❒	Too little sleep/insomnia	❒	❒	Violent actions	❒	❒	Compulsions
❒	❒	Too much sleep	❒	❒	Destroy property	❒	❒	Hard to control worrying
❒	❒	Body image concerns	❒	❒	Easily annoyed/irritated/on edge	❒	❒	Easily startled
❒	❒	Esteem problems	❒	❒	Impulsive-act before thinking	❒	❒	Avoid places/situations
❒	❒	Weight loss	❒	❒	Easily distracted/frustrated	❒	❒	Difficulty meeting people
❒	❒	Weight gain	❒	❒	Difficulty paying attention	❒	❒	Uneasy in crowds
❒	❒	Poor appetite	❒	❒	Feeling confused	❒	❒	Distressing dreams/nightmares
❒	❒	Overeating	❒	❒	Elevated or hyper mood	❒	❒	Night terrors
❒	❒	Anorexia	❒	❒	Increased activity level	❒	❒	Sexual concerns
❒	❒	Mood swings	❒	❒	Racing thoughts	❒	❒	Sexual indifference

R	P		R	P		R	P	
❒	❒	Unusual perceptions	❒	❒	Alcohol/drug problems	❒	❒	Work/school problems
❒	❒	Paranoid/suspicious thoughts	❒	❒	High-risk taking behaviors	❒	❒	Unfulfilled in career
❒	❒	Disorganized thoughts	❒	❒	Injuring or harming yourself	❒	❒	Learning disabilities/problems
❒	❒	Hallucinations	❒	❒	Relationship problems	❒	❒	Housing/economic problems
❒	❒	Delusions	❒	❒	Family problems	❒	❒	Legal problems
❒	❒	Excessive behaviors (sex/gambling/shopping/computers)	❒	❒	Social support problems	❒	❒	Others (*specify below*)

Behaviors & problems (others): ______________________________

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Have these interfered with your ability to function?: ❒ emotionally ❒ physically ❒ socially ❒spiritually ❒ at home ❒ at work ❒ at school ❒ in legal matters Explain how: ______________________________

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Mental Health Treatment History

	No	Yes	When/Frequency	Counselor Name/Location	Treatment Length
Past therapy	❒	❒			
Current counseling services	❒	❒			
Suicidal thoughts/attempts	❒	❒			
Drug/alcohol treatment	❒	❒			
Hospitalizations	❒	❒			
Support Groups (AA, Al-Anon, NA, etc.)	❒	❒			
Were you abused as a child?	❒	❒			
Do you drink alcohol?	❒	❒			
Do you use drugs?	❒	❒			

What, if any, medications or supplements are you currently taking? (name, dose): ______________________________

____

Past medications and supplements?: ______________________________

____

Medical History

Do you have any known allergies to medications? ❒ No ❒ Yes If yes, describe: ______________________________

____

Any history of thyroid disease? ❒ No ❒ Yes

Any history of excessive hair loss/dry skin/feeling cold? ❒ No ❒ Yes

What were the results of your last physical exam?: ______________________________

Do you have any medical problems? ❒ No ❒ Yes If yes, describe: ______________________________

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____

List past surgeries, hospitalizations, serious injuries, and head injuries: ______________________________

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Check all that apply to you:

- ❒ Aids
- ❒ Alcoholism
- ❒ Allergies
- ❒ Anemia
- ❒ Apnea
- ❒ Arthritis
- ❒ Asthma
- ❒ Birth defects
- ❒ Brain injury
- ❒ Cancer
- ❒ Childhood diseases
- ❒ Chronic pain
- ❒ Diabetes
- ❒ Drug abuse
- ❒ Epilepsy
- ❒ Headaches
- ❒ Hearing problems
- ❒ Heart problems
- ❒ Hepatitis
- ❒ Hiv
- ❒ High blood pressure
- ❒ Indigestion problems
- ❒ Kidney problems
- ❒ Liver problems
- ❒ Low blood pressure
- ❒ Multiple sclerosis
- ❒ Neurological disorders
- ❒ Rheumatic fever
- ❒ Serious infections
- ❒ Sexually-transmitted diseases
- ❒ Stroke
- ❒ Thyroid problems
- ❒ Tuberculosis
- ❒ Vision problems
- ❒ Other: ___________________
- ❒ Other: ___________________

Family/Childhood History

Biological Family History

Substance abuse? ❒ No ❒ Yes ❒ Unknown

Psychiatric problems? ❒ No ❒ Yes ❒ Unknown

Adoptive/Step/Legal Guardian Medical History

Substance abuse? ❒ No ❒ Yes ❒ Unknown

Psychiatric problems? ❒ No ❒ Yes ❒ Unknown

List relationship and problems: ____

____

____

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Developmental History

How were your grades in elementary school?: ____________________ High School?: ____________________

Were you ever disruptive in class? ❒ No ❒ Yes Did anyone ever call you hyperactive? ❒ No ❒ Yes

Are you currently enrolled in school? ❒ No ❒ Yes If yes, ❒ High School/GED ❒ Vocational/College ❒ Graduate ❒ Other: ____

Mother's age: _________ Father's age: _________ Number of brothers: _______ Number of sisters: _______

If your parents have separated or divorced, how old were you then?: ____ How did you feel about it?: _______

____

____

Were you adopted or raised with someone other than your natural/biological parents? ❒ No ❒ Yes

If yes, who? ____

Comments/Other information: ____

____

____

____

Chemical Use History

Have you ever abused alcohol or drugs? ❒ No ❒ Yes If yes, when, how much, how long?: _______________

____

Reasons for use: ❒ addicted ❒ build confidence ❒ escape ❒ self-medication ❒ socialization ❒ taste ❒ other: ____

Have you had adverse reactions or overdose to drugs or alcohol? ❒ No ❒ Yes If yes, describe: ___________

____

Substance of preference: 1.____________________ 2.____________________ 3.____________________

Patient Confidentiality applies to all information provided above.

Check all that apply:

- ❒ Alcohol
- ❒ Amphetamines
- ❒ Barbiturates
- ❒ Caffeine
- ❒ Cocaine/Crack
- ❒ Crystal/Methamphetamine
- ❒ Ecstasy
- ❒ GHB
- ❒ Heroin/Opiates
- ❒ Inhalants
- ❒ Ketamine
- ❒ LSD/Mescaline
- ❒ Marijuana
- ❒ Nicotine/Cigarettes
- ❒ Over the Counter
- ❒ PCP
- ❒ Prescription Drugs
- ❒ Speed
- ❒ Valium/Librium
- ❒ Other: ________________
- ❒ Other: ________________

Comments/Other information: ____

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____

Personal Goal

Who lives at home with you? (list name, age, and relationship to you): ____

____

____

What do you want to accomplish in therapy?: ____

____

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Check all of the following qualities and areas of your life you would like to enhance:

- ❒ Creativity
- ❒ Emotions
- ❒ Happiness
- ❒ Motivation
- ❒ Enthusiasm
- ❒ Life Direction
- ❒ Sense of Humor
- ❒ Friendships
- ❒ Communication
- ❒ Work
- ❒ Mindfulness
- ❒ Finding Passion
- ❒ Accepting Self
- ❒ Managing Time
- ❒ Confidence
- ❒ Intimacy
- ❒ Relationships
- ❒ Leadership Skills
- ❒ Compassion
- ❒ Love
- ❒ Public Speaking
- ❒ Spiritual Awareness
- ❒ Forgiveness
- ❒ Honesty
- ❒ Concentration
- ❒ Social Life
- ❒ Time for Family
- ❒ Conflict Resolution
- ❒ Life Purpose
- ❒ Letting Things Go
- ❒ Self-Image
- ❒ Money/Financial
- ❒ Personal Boundaries
- ❒ Relaxation
- ❒ Sexual Satisfaction
- ❒ Physical Health
- ❒ Embracing Success
- ❒ Listening Skills
- ❒ Taking Responsibility
- ❒ Contributing to Community
- ❒ Activity Level
- ❒ Personal Power

Who or what is your support system?: ____

____

____

____

Any additional information that you think we should know?: ____

____

____

____

Do you feel suicidal at this time? ❒ No ❒ Yes If yes, explain: ____

____

____

____

Emergency Contact 1: ______________________ Relationship: _______________ Phone: ____________________

Emergency Contact 2: ______________________ Relationship: _______________ Phone: ____________________

Signature: ____ Date: ________________________

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