Christine Hards, M.Ed, LPC
All Things Counseling, PLLC

New Client Questionnaire/Psychosocial History
(To be completed by the client)

Please complete this form to the extent that you feel comfortable. If any questions are particularly difficult, painful, or not applicable, please feel free to leave them blank and/or discuss them with me during your session. If you need more space for any answers, please use margins or back of sheet.

Name: _____ **Date:**_____

Phone Number: _____ **Gender: ___F ___M Date of Birth:**_____

Email Address: _____ **Age:**_____

Address:
_____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Referred By:_____
(e.g., Name of physician, website, friend, yellow pages, etc.)

Primary reason(s) for seeking services:_____
_____

Family Information

Relationship	Name	Age	Living? Yes	Living? No	Lives with you? Yes	Lives with you? No
Mother						
Father						
Spouse/Partner						
Children/Siblings						

Significant others (e.g., siblings, grandparents, etc.) Please specify relationship.

Relationship	Name	Age	Living? Yes	Living? No	Lives with you? Yes	Lives with you? No

Client Name:_____ Date:_____

Current Marital Status: (please circle all that apply)

Single	Married	Living together	Committed relationship
Divorced	Widowed	Engaged	Separated

Length of current marriage/relationship: _____

Number of marriages/serious relationships: _____

Assessment of current relationship (if applicable):

I feel safe in my current living situation: ☐ Yes ☐ No (please explain)

I feel safe in my current romantic relationship: ☐ Yes ☐ No (please explain)

Growing up, I was raised by/lived with:

My childhood was:

I usually get along with my parents: ☐Yes ☐No because:

I usually get along with my siblings: ☐Yes ☐No because:

Development

Are there any special, unusual, or traumatic circumstances that affected your development?

Client Name:_____ Date:_____

Type of discipline used in my home when growing up:

_____
_____
_____

Has there been a history of abuse in your past? ☐ Yes ☐ No

If yes, which type(s):
☐Emotional/verbal abuse ☐Physical ☐ Sexual ☐Neglect/Abandonment

Comments:_____
_____
_____
_____

Social Relationships

I usually get along with other adults: ☐Yes ☐No because:_____
_____
_____
_____

I usually get along with children: ☐Yes ☐No because:_____
_____
_____
_____

I have friends: ☐ No ☐ Yes #_____Males #____Females

Sexual orientation: _____ **Comments:** _____

Sexual problems or dysfunction: ☐ Yes ☐ No
If yes, describe: _____

Cultural/Ethnic

With which cultural, racial, or ethnic groups do you identify? _____

Are you experiencing any concerns related to cultural, racial, or ethnic issues? ☐No ☐Yes If yes, please describe: ____
_____
_____
_____

Other pertinent cultural/racial/ethnic information:
_____
_____
_____

Religious/Spiritual Affiliation:
_____
_____
_____

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Client Name:_____ Date:_____

Would you like your spiritual/religious beliefs incorporated into therapy? ☐ Yes ☐No
If yes, please describe:

_____
_____
_____

Legal

I have been involved with the legal system: ☐No ☐Yes Describe:

_____
_____
_____

Education/Employment

Highest level of education completed (including school name and diploma/degree):

_____
_____
_____

Currently enrolled as a student? ☐ No ☐ Yes

Current employer: ☐ N/A_____

Job title/Occupation: ☐ N/A _____

Career Concerns? _____

Military experience (i.e., branch, rank, type of discharge, combat experience, etc.): ☐N/A_____

_____
_____
_____

Medical/Physical Health

I have the following medical problems:

_____
_____
_____

List all current medical issues and past accidents/surgeries/medical issues that may still affect you presently.

I take the following prescription or over the counter medications including vitamins/supplements/herbs:

Name of medicine	Reason

Use additional space at bottom/back of this page if needed.

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Client Name:_____ Date:_____

Please describe any recent changes in sleep, eating, behavior, weight, disposition, or energy level:

_____
_____
_____

List any concerns you may have about your sleep and/or eating habits:

_____
_____
_____

Chemical Use History

I have used the following types of alcohol/illegal substances: put a * by your drug of choice

Name of drug	Age of first use	Amount/Frequency	Date of last use

Are you or someone you love concerned about your use of alcohol or drugs?
☐ Yes ☐ No

Have you ever sought help (inpatient treatment or 12 step program) for substance abuse or addiction?
☐ Yes ☐ No If yes, please describe: _____

_____
_____
_____

Please list any family history of drug or alcohol abuse:

_____
_____
_____

Counseling/Prior Treatment History

I have cut, burned, scratched, or hurt myself before: ☐No ☐ Yes If yes, please explain:_____

_____
_____
_____

I have attempted suicide before: ☐ No ☐ Yes If yes, please explain:_____

_____
_____
_____

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Client Name:_____ Date:_____

Are you currently suicidal? ☐ No ☐ Yes
If yes, please explain:

_____
_____
_____

I have thought about killing someone else: ☐ No ☐ Yes because:_____
_____
_____
_____

I have had previous treatment (e.g., inpatient, private therapist, residential treatment):
☐ No ☐ Yes because:_____
_____
_____
_____

If you have previously seen a therapist, what did you like or dislike about that experience_____
_____
_____
_____

I am willing to receive therapy: ☐ No because:_____**☐ Yes because:**_____
_____
_____
_____

What are your expectations or goals for therapy? _____
_____
_____
_____

Please list any other information that might be helpful in understanding you or assist in your therapy:_____
_____
_____
_____
_____
_____
_____

Client or Legal Guardian Name:_____

Client or Legal Guardian Signature:_____