Psychotherapy Client Questionnaire

If you are uncomfortable answering a question, leave it blank and we can address it in session.

Limits of Your Confidentiality:

As a psychotherapy client, it is important for you to know the limits of your confidentiality. California State law and professional ethics require therapists to maintain client confidentiality except in the following circumstances:

a. If there is suspected child abuse, elder abuse or dependent adult abuse.
b. "Tarasoff" and "Ewing" situations in which serious threat to a reasonably identified victim is communicated to the therapist.
c. When a threat to injure of kill oneself is communicated to the therapist.
d. If you are required to sign a release of medical records by you healthcare insurance company.
e. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with public or private agencies. Think carefully and consult with an attorney before you sign away your rights. We can discuss some foreseeable possibilities together.
f. Clients being seen as a couple are legally obligated to maintain their partner's confidentiality. The therapist will exercise discretion (but cannot promise absolute confidentiality} when disclosing private information to other participants involved in your treatment process. Secrets cannot be kept by the therapist from others whom are involved in your treatment process.
g. I may at times consult with other professional about our work together without asking your permission but your identity will be disguised.
h. It is also important that you are aware of other potential limits to your confidentiality including:
i. All psychotherapy records including session notes, session recordings, phone records, text messages, faxes, emails and billing records can be subject to court subpoena under certain extreme circumstances.
j. All electronic communication compromises your confidentiality.
k. Most records are stored in locked files but some are stored on electronic devices.

Your signature confirms that you have read and understand these limits to confidentiality:

Client signature: _____ Date: _____

Therapist signature: _____ Date: _____

Psychotherapy Client Questionnaire

If you are uncomfortable answering a question, leave it blank and we can address it in session.

Client Information:

Name: _____ DOB: _____ Birthplace: _____

Adress: _____

Phone numbers: Primary _____ Secondary: _____

Email: _____

Education level: _____ Degree obtained: _____

Profession: _____

Employer: _____

Job Title: _____

How long at this position? _____

Marital status: Single: _____ Married _____ Divorced _____

If married, is it your 1st _____ 2nd _____ 3rd _____ marriage?

When were you last married or divorced ? _____

What is your current living situation: _____

Names & ages of any biological, adopted and stepchildren:

1. Name: _____ Age: _____
2. Name: _____ Age: _____
3. Name: _____ Age: _____

Emergency contacts:

1. Name: _____

Phone number(s): Primary: _____ Secondary: _____

What is your relationship with this person? _____

Do they know you are in therapy? _____

2. Name: _____

Phone number(s): Primary: _____ Secondary: _____

What is your relationship with this person? _____

Do they know you are in therapy? _____

Do I have your permission to inform emergency contacts if you are ever in danger?

Yes _____ No _____

What is the main reason or your chief complaint for seeking therapy?:

_____

_____

_____

_____

Psychotherapy Client Questionnaire

If you are uncomfortable answering a question, leave it blank and we can address it in session.

If you are self-referred, how long have you thought about therpay?

If someone else recommend therapy, who did and what do you think their concern is?

What prevented you from starting therapy earlier and why start therapy now?

What are your goals for this therapy?

Give a brief history of your most important interpersonal relationship:

How do you usually spend most of your time?

Present interests, hobbies, activities:

What are your life goals:

Psychotherapy Client Questionnaire

If you are uncomfortable answering a question, leave it blank and we can address it in session.

What are your greatest fears:

1. _____
2. _____
3. _____
4. _____
5. _____

Family History:

Father's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

Your age at time of father's death: _____

Brief description of his personality:

_____

_____

_____

_____

_____

Mother's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

Your age at time of father's death: _____

Brief description of her personality:

_____

_____

_____

_____

_____

Siblings: (names, gender, age, and something about each of them)

_____

_____

_____

Significant others during your childhood & adolescence:

_____

_____

_____

Psychotherapy Client Questionnaire

If you are uncomfortable answering a question, leave it blank and we can address it in session.

Who are the most important people in your life now? Describe these relationships.

_____

_____

_____

_____

_____

_____

_____

Previous Psychiatric and/or Psychotherapy Contacts:

Have you ever been in psychotherapy before?: Yes ____ No ____

If yes, when? _____

May I contact your previous therapist(s)? Yes ____ No ____

Therapist: _____

Address: _____

Phone: _____

Therapist: _____

Address: _____

Phone: _____

Have you ever been hospitalized for an emotional problem? Yes ____ No _____

If so, why, when, where, and how long?

_____

_____

Have you ever made a suicide attempt? Yes ____ No _____

If yes, describe it, when, and the circumstances leading up o the attempt:

_____

_____

_____

Have any close relatives been treated for mental health issues?

If yes, please specify:

_____

_____

Have any relatives died by suicide?

If yes, please specify:

_____

Psychotherapy Client Questionnaire

If you are uncomfortable answering a question, leave it blank and we can address it in session.

If you feel comfortable with it, briefly describe any childhood and/or adolescence abusive experiences (verbal, physical, sexual) including what happened and who it was that abused you. Example: Age 10, physical abuse by family member.

Give a brief history of any litigation you have been involved in regarding child custody, divorce, liability or medical malpractice:

Self-Description: Give a "word picture" of yourself, Describe yourself in terms of how you presently feel and see yourself, including both the negatives and positives:

Personal Medical History

Have you ever had any of these childhood illnesses?

	Yes	No	Don't Know
Measles:	_____	_____	_____
Mumps:	_____	_____	_____
Whooping cough:	_____	_____	_____
Chicken pox:	_____	_____	_____
Rheumatic fever:	_____	_____	_____
Rubella (German measles)	_____	_____	_____

Psychotherapy Client Questionnaire

If you are uncomfortable answering a question, leave it blank and we can address it in session.

Medical hospitalizations, surgeries, dates and diagnoses:

_____

_____

_____

Have you ever suffered from any of the following illnesses:

	Yes	No	Don't Know
Cancer	_____	_____	_____
Tuberculosis	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid problems	_____	_____	_____
Kidney problems	_____	_____	_____
High blood pressure	_____	_____	_____
Low blood pressure	_____	_____	_____
Heart problems	_____	_____	_____
Neurological disease	_____	_____	_____
Ulcers	_____	_____	_____
Head injury	_____	_____	_____
Allergies	_____	_____	_____

Medical Symptoms:

Check any of the following symptoms that apply to you at this time. Also indicate when any of these have applied to you:

Fainting	_____	Difficulty sleeping	_____
Alopecia	_____	Excessive thirst	_____
Seizures	_____	Blurred vison	_____
Weight gain/loss	_____	Dry skin	_____
Fatigue	_____	Hearing loss	_____
Constipation	_____	Tinnitus	_____
Alcohol withdrawal	_____	Tremors	_____
Drug withdrawal	_____	Chest pains	_____
Trouble breath	_____	Disordered eating	_____
Foor/ankle swelling	_____	Indigestion	_____
Diarrhea	_____	Nausea or vomiting	_____
Headaches	_____	Vertigo	_____
Urinary difficulties	_____	Sexual dysfunction	_____

Psychotherapy Client Questionnaire

If you are uncomfortable answering a question, leave it blank and we can address it in session.

List all allergies:

_____

_____

Sleep habits: describe your sleep routine, problems/concerns. Nightmares? Repeating dreams?

_____

_____

_____

Drug/alcohol history:

- Do you drink alcohol? Yes____ No _____. If yes, how often, how many and what type?

  _____
- Have you ever had a 'black-out'?
- Do you smoke and/or vape nicotine? Yes_____ No _____
- If yes, what and how often?

  _____
- What happens to you when you smoke or drink, that is what does it do for you and what does it do to you?

Family medical history: Have any of your blood relatives suffered from any of the illnesses, addictions or conditions listed above? If yes, please specify the illness and the relative.

_____

_____

_____

Menstrual history:

- Age at menarche? _____
- Is you premenstrual syndrome (PMS) 'Mild', 'Moderate' or 'Severe'? (Circle one)
- Have you ever been diagnosed with premenstrual dysphoric disorder (PMDD)?
- Have you been prescribed medication for PMS or PMDD?
- If yes, please specify:_____
- List other menstrual problems:

  _____

  _____

Any other serious illness or conditions?

_____

_____

Psychotherapy Client Questionnaire

If you are uncomfortable answering a question, leave it blank and we can address it in session.

What forms of physical exercise do you participate in and how often?

_____

_____

Describe the spiritual/religious aspects of your life:

_____

_____

Have you ever been hypnotized? If so, for what and what was the outcome?

_____

_____

Have you ever been on worker's comp or disability? For what, how long, outcome?

_____

_____

_____

Is there anything else that I need to know about you so I can understand you better?

_____

_____

What are your concerns about therapy?

_____

_____

Client signature: _____ Date{ _____

Therapist signature: _____ Date: _____

(End of document)