BRINDLEY GROUP, LLC

Date:_____/_____/_____

Client Questionnaire

Full Name: _____ Preferred Name:_____

Marital Status: S M D W If married, how long?_____Spouse's Name_____

Person to contact in case of emergency:_____Telephone:_____

People and pets currently in household, including yourself

Name	Relationship to Client	Age	Gender	Educational Level	Occupation

Continue on back if necessary

Any children not living in household? _____

What is your primary concern that led you to seek counseling?

_____

_____

_____

What other concerns do you have?

_____

_____

_____

Have you had any recent changes in your life?

_____

_____

_____

Tell us about your education history. Any learning difficulties in school? Regrets with education?

Tell us about your work history, as well as any current work. What parts of work do you enjoy and what creates stress. This includes working as a stay at home parent.

Tell us about relationship history, as well as current relationship. Include any intimacy issues.

Tell us about your sexual orientation, as well as your gender identity.

Tell us about your spiritual/religious belief, if applicable. Any concerns?

Describe your childhood, including what was your relationship was like with your family of origin.

Please describe any "yes" answers to the questions below.

Do you have anxiety or worry on a regular basis? ___Yes ____No _____

_____

Are you consistently sad or have a depressed mood most of the day or nearly every day?____Yes_____No

_____

Do you have a diminished level of interest in most or all activities?_____Yes___No ___

_____

Change in appetite?__Yes___No _____

Change in weight?_____Yes_____No _____

Change in sleep pattern?_____Yes_____No _____

Average hours of sleep? ___ Concern that you have a sleep disorder? Yes___No _____

Fatigue or loss of energy?_____Yes_____No _____

Feelings of worthlessness or excessive guilt?_____Yes_____No_____

Difficulty thinking or concentrating?_____Yes_____No _____

Thoughts of death or suicide (or any attempts)?_____Yes_____No _____

Thoughts of self harm or self harm?_____Yes_____No _____

Increased irritability or violent behavior?_____Yes_____No _____

Panic Attacks? ___Yes___No_____

Any phobias or unusual fears?_____Yes_____No _____

Ever experience a "natural high" in absence of substance abuse (with increased energy, mood, decreased need for sleep, talkativeness, etc.)?__Yes_____No _____

Any history of eating disorder or disordered eating? ____Yes____No_____

_____

Any use of laxatives, diuretics, diet pills, purging, food restriction, or other? (Please circle and describe) ___

_____

Describe your history and current use of alcohol, drug use, including nicotine/vaping/prescription overuse.

If applicable, describe history and current involvement of recovery groups and / or substance use treatment.

Describe any legal issues (Ex. DUI, etc.).

Do you struggle with any other addictive behaviors (Ex. Gaming, Porn, Gambling, Working out, etc.)

Describe your history and current use of caffeine.

Have you experienced traumatic events as a child/teen or adult? (Briefly describe)

Have you ever been in therapy? What was helpful/not helpful?

Any medical problems (i.e. thyroid, chronic issues, headaches, diabetes etc.)?

Any prior hospitalizations (Psychiatric or medical)?

Are you currently under the care of a physician and/or psychiatrist? If so, whom? And for how long?

List all medications you are currently or have recently taken. Give names, dosage and duration of usage.

Family medical history (Ex. Diabetes, Narcolepsy, Thyroid issues, etc.):

Family mental health history (Ex. Alcoholism/depression/anxiety/bipolar, etc.):

Is there anything else that would be helpful for me to know about? _____

What do you hope or expect to gain from therapy? _____

Thank you for taking the time to complete this information, as this helps me help you!

SIGNATURE_____DATE_____