Client Treatment Questionnaire

Name: Date: Case#:

Please describe briefly why you are seeking therapy.

|  |  |
| --- | --- |
| Have you recently experienced any of the following?0 = None, 1= Mild, 2 = Moderate, 3 = Severe | Have you or a family member experienced any of the following recently or in the past? |
|  | 0 | 1 | 2 | 3 |  | You | Family |
| Anxiety |  |  |  |  | Major Illness or Pain |  |  |
| Depressed Mood |  |  |  |  | Medical Hospitalization |  |  |
| Anger/Irritability |  |  |  |  | Psych Hospitalization |  |  |
| Fear |  |  |  |  | Thyroid Problems |  |  |
| Worrying |  |  |  |  | Menopausal Issues |  |  |
| Difficulty Sleeping |  |  |  |  | Mental Illness |  |  |
| Changes in Weight |  |  |  |  | Suicide (or attempts) |  |  |
| Difficulty Concentrating |  |  |  |  | Eating Disorder |  |  |
| Low Energy |  |  |  |  | Alcoholism |  |  |
| Suicidal Thoughts |  |  |  |  | Drug Addiction |  |  |
| Homicidal Thoughts |  |  |  |  | Physical Abuse |  |  |
| Other Symptoms: (list below) |  |  |  |  | Sexual Abuse |  |  |
|  |  |  |  |  | Emotional Abuse |  |  |
|  |  |  |  |  | Domestic Violence |  |  |
|  |  |  |  |  | Death of a Loved One |  |  |
|  |  |  |  |  | Other Stressors: (list below) |  |  |
|  |  |  |  |  |  |  |  |

How would you rate the severity of the symptoms you have noted above? (circle one)

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Severe Moderate Mild

How would you rate your overall functioning at present? (circle one)

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Unable to Serious Moderate Mild No

Function Difficulty Difficulty Difficulty Difficulty

In All Areas Functioning Functioning Functioning Functioning

Do you have any current medical/physical conditions?

Name of you Primary Care Physician/Medical Professional:

Date of your last medical exam: With whom?

Reason: Recent hospitalization? Reason:

Please list any prescription medication you are currently taking:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Purpose | Prescriber |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please list and describe use of any of the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | How often? | Amount & Type |
| Coffee or Tea |  |  |  |  |
| Soda Pop |  |  |  |  |
| Alcohol |  |  |  |  |
| Cigarettes/chewing tobacco |  |  |  |  |
| Marijuana/Cannibus |  |  |  |  |
| Other Drugs |  |  |  |  |

Has your use of any of the above changed recently? Yes No

If yes, in what way?

Have you ever been treated for an addiction? Yes No

If yes, when and for what type?

Type of addiction treatment (inpatient, outpatient, 12 Step, etc.):

Have you ever seen a therapist before? Yes No

If yes, when and for how long?

Is there anything else you’d like me to know?