NEW CLIENT QUESTIONNAIRE

Andy Dunn, LMFT

COUNSELING FOR COUPLES, FAMILIES & INDIVIDUALS

EMDR

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PLEASE PRINT

Today's Date ____________________ Referred by ____________________

Name(s) ____________________ Spouse/Other ____________________

Occupation ____________________ Spouse/Other Occupation ____________________

Phone Number (where you prefer to be contacted) ____________________ Spouse/Other Phone ____________________

Street Address ____________________ Spouse/Other Street Address ____________________

City ________ State ________ Zip ________ City ________ State ________ Zip ________

Date of Birth ____________________ Spouse/Other Date of Birth ____________________

E-mail address(es) ____________________

Marital Status: ❑ Single ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Remarried

List members of your family and/or all others living in your home:

Name	Sex	Age	Relationship to you

Briefly describe your reason for seeking help: ____________________

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When were you last examined by a physician? ________________

Name of physician: ________________ Phone Number: ________________

List any major health problems for which you currently receive treatment: ________________

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List all medications you are now taking: ________________

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Have you received psychiatric or psychological treatment or counseling before? ❑ Yes ❑ No

If yes, please give name(s) of provider(s), location(s) and treatment dates: ________________

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Please check all that apply to you:
(If attending therapy as a couple, please initial each symptom as it applies to you individually)

- ❑ Depression
- ❑ Loss/Grief Issues
- ❑ Drug/Alcohol Use
- ❑ Anger/Rage
- ❑ Pornography
- ❑ Self-worth
- ❑ Financial Concerns
- ❑ Sexual Struggles
- ❑ Suicidal Thoughts
- ❑ Stress
- ❑ Anxiety/Fears
- ❑ Divorce or Separation
- ❑ Eating Disorder
- ❑ Body Image/Weight Concerns
- ❑ Sleep Problems
- ❑ Loneliness
- ❑ Marital Struggles
- ❑ Premarital Concerns
- ❑ History of Abuse
- ❑ Parenting Struggles
- ❑ Lack of Concentration
- ❑ Headaches/Other Pain
- ❑ Problems at Work/School
- ❑ Health Concerns
- ❑ Friendship Struggles
- ❑ Spiritual Concerns
- ❑ Struggles with: (circle) Pregancy, Infertitlity, Miscarriage, Postpartum Depression
- ❑ Adoption Preparation and Concerns (Pre and Post Adoption)
- ❑ Compulsive Behavior (Sex, Shopping, Gambling, Risk Taking, etc.)
- ❑ Other: ________________

Regarding the items you checked above, use the space below to list the item(s) on which you would most like to focus your therapy. Then rate each one (where applicable) on its level of disturbance to you using a scale from 0 (no disturbance) to 10 (high disturbance). “Disturbance” can relate to how much it bothers you or impacts your daily functioning. (Example: Depression - 10, Body Image - 8)

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It is important for the client and therapist to agree on a course of therapy and types of interventions that best fit the client's individual personality and goals for therapy. Your answers in the following questions help me learn more about you and understand your view of therapy and commitment to the process:

In a few words, what do you think therapy is all about?

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How long do you think therapy should last? How long are you able to commit to therapy?

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What personal qualities do you think the ideal therapist should possess?

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What types of self-care practices have been helpful to you in the past when dealing with difficult situations? These may be things you learned from previous therapy or discovered on your own. Examples: journaling, exercising, workbooks, prayer, support groups.

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What are some of your hobbies/interests?

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I have/will read the Counseling Policies provided to me to review, and I agree to abide by the terms.

Signature of responsible party______________________________ Date ______________________________