BALANCED LIFE COUNSELING LLC

CLIENT QUESTIONNAIRE

Client's Name: _____ Date: _____

Phone #: _____ Alt Phone: _____ Best time to contact: _____

Marital Status: [ ]Single (never married) [ ]Engaged [ ]Married [ ]Separated [ ]Divorced [ ] Widowed

Please give us the name of your spouse or significant other: _____

Describe this relationship: _____

Would you like this person to be involved in your counseling? [ ]Yes [ ]No

(WRITTEN CONSENT MUST BE GIVEN AUTHORIZING RELEASE OF INFORMATION. PLEASE REQUEST THIS FORM, (if this person will be involved in your counseling)

GENERAL INFORMATION

Name of family/primary physician: _____

Please list your current medical problems and medications you are taking: _____

_____

_____

_____

Please list any allergies to medication: _____

Are you currently employed? [ ]Yes [ ]No If yes, please give name of company and hours/days you work: _____

_____

Are you currently involved with the legal system (pending case, probation, parole)? [ ]Yes [ ]No If yes, please explain: _____

_____

_____

Education: [ ]Less than high school [ ]G.E.D. [ ]College: number of years: _____

What is the main reason for seeking therapy? _____

_____

_____

_____

_____

Have you previously received therapy? [ ]Yes [ ]No If yes, please state when, who with and how it helped you: _____

_____

_____

Have you ever been hospitalized for mental health issues? [ ]Yes [ ]No If yes, please tell us when you were hospitalized and where: _____

_____

Have you ever attempted suicide? [ ]Yes [ ]No If yes, please indicate when and the circumstances __

_____

_____

Have you ever received treatment for substance abuse? [ ]Yes [ ]No If yes, please explain where you received treatment and what substance you used: _____

_____

Who do you live with now? _____

Are you satisfied with your living arrangements? _____ If not, why: _____

_____

Do you have transportation difficulties? [ ]Yes [ ]No If yes, please explain: _____

_____

Rate your home life: [ ]Great [ ]Pretty good [ ]Not too bad [ ]Bad

Any recent deaths/losses [ ]Yes [ ]No If yes, how long ago? _____

Are you having persistent thoughts, impulses or images that you do not want? [ ]Yes [ ]No

If yes, please explain: _____

_____

Does that cause you anxiety or to worry? [ ]Yes [ ]No

Are they real life problems or more vague? _____

Do you use any behaviors to try and prevent thoughts, impulses, and images from happening? If so, explain: _____

_____

Are you experiencing flashbacks, dreams or nightmares? Describe _____

_____

_____

Do you feel a sense of hyper-vigilance or have an exaggerated startled response? _____

_____

Do you feel like you are choking, shaky, sweaty, dizzy, lightheaded or faint, like a panic attack? Yes No

Do you feel like you are losing control or that you are going crazy? [ ]Yes [ ]No

SPIRITUAL STATUS

Do you consider yourself a religious person? [ ]Yes [ ]No If yes, what denomination: _____

_____

Do you attend church? [ ]Yes [ ]No If yes, how often? _____

Do you want to have Christian Counseling as part of our services? [ ]Yes [ ]No

Do you believe in prayer? [ ]Yes [ ]No

Do you read the Bible and pray daily each week? [ ]Yes [ ]No

Have you ever heard the term "Born again?" [ ]Yes [ ]No

If not, would you like to know more about it and what it means? [ ]Yes [ ]No

On the rest of this page write any additional information you would like us to know. Also, we would like to encourage you to tell us what you hope to gain from counseling.

EMOTIONAL CHECKLIST

Circle the one which best describes your feelings.

Headaches	none	slight	serious	severe	overwhelming
Upset stomach	none	slight	serious	severe	overwhelming
Diarrhea	none	slight	serious	severe	overwhelming
Constipation	none	slight	serious	severe	overwhelming
Physical pain	none	slight	serious	severe	overwhelming
Problems with breathing	none	slight	serious	severe	overwhelming
Hot or cold spells	none	slight	serious	severe	overwhelming
Sadness/depression	none	slight	serious	severe	overwhelming
Suicidal thoughts	none	slight	serious	severe	overwhelming
No emotions	none	slight	serious	severe	overwhelming
Irritability	none	slight	serious	severe	overwhelming
Anger	none	slight	serious	severe	overwhelming
Racing thoughts	none	slight	serious	severe	overwhelming
Confusion	none	slight	serious	severe	overwhelming
Difficulty keeping on task	None	Slight	Serious	Severe	overwhelming
Difficulty concentrating	none	slight	serious	severe	overwhelming
Difficulties controlling my thoughts	none	slight	serious	severe	overwhelming
Forgetful	none	slight	serious	severe	overwhelming
Forget in the middle of a thought	None	Slight	Serious	Severe	overwhelming
Overly talkative	none	slight	serious	severe	overwhelming
Difficulty communicating	none	slight	serious	severe	overwhelming
Tired a lot	none	slight	serious	severe	overwhelming
Restless/can't sit still	none	slight	serious	severe	overwhelming
Nervous/tense	none	slight	serious	severe	overwhelming
Anxious	None	Slight	Serious	Severe	overwhelming
Panicky	none	slight	serious	severe	overwhelming
Shaky/trembling	none	slight	serious	severe	overwhelming
Worry alot	none	slight	serious	severe	overwhelming
Interest in things of Life	none	slight	serious	severe	overwhelming
Loss of appetite	none	slight	serious	severe	overwhelming
Feel like eating all the time	None	Slight	Serious	Severe	overwhelming
Loss of weight without dieting	none	slight	serious	severe	overwhelming
Gaining weight without trying to	none	slight	serious	severe	overwhelming
Quick change of moods	none	slight	serious	severe	overwhelming
Feeling negative about the future	none	slight	serious	severe	overwhelming
Mood swings	none	slight	serious	severe	overwhelming
See/ Hear strange things	none	slight	serious	severe	overwhelming
Feel like someone is watching me	none	slight	serious	severe	overwhelming
Dwelling on problems	none	slight	serious	severe	overwhelming
Feel like someone/something controls you	none	slight	serious	severe	overwhelming
Feeling others are out to get me	none	slight	serious	severe	overwhelming
Feel hopeless	none	slight	serious	severe	overwhelming
Feel guilty	none	slight	serious	severe	overwhelming
Hard to trust anyone	none	slight	serious	severe	overwhelming
Feeling helpless	none	slight	serious	severe	overwhelming
Feeling worthless	none	slight	serious	severe	overwhelming
Feel ignored/abandoned/rejected	none	slight	serious	severe	overwhelming

Drawing away from people	none	slight	serious	severe	overwhelming
Feeling lonely	none	slight	serious	severe	overwhelming
Feel used by people	none	slight	serious	severe	overwhelming
Trouble sleeping	none	slight	serious	severe	overwhelming
Getting to sleep	None	Slight	Serious	Severe	Overwhelming
Can't get back to sleep	None	Slight	Serious	Severe	overwhelming
Difficulty waking up	None	Slight	Serious	Severe	overwhelming
Too many fears	none	slight	serious	severe	overwhelming
Use drugs	none	slight	serious	severe	overwhelming
Use alcohol	none	slight	serious	severe	overwhelming
Other drug use	none	slight	serious	severe	overwhelming
Boyfriend/girlfriend Problems	none	slight	serious	severe	overwhelming
Sexual problems	none	slight	serious	severe	overwhelming
Parents/step-parents problems	none	slight	serious	severe	overwhelming
Problems with my children	none	slight	serious	severe	overwhelming
Friend problems	none	slight	serious	severe	overwhelming
Work/school problems	none	slight	serious	severe	overwhelming
Health/medical problems	none	slight	serious	severe	overwhelming
Mental health problems	none	slight	serious	severe	overwhelming
	none	slight	serious	severe	overwhelming
Other:	none	slight	serious	severe	overwhelming
	none	slight	serious	severe	overwhelming

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