

# HEALING THERAPEUTIC SERVICES, LLC

## CLIENT QUESTIONNAIRE

*“Please complete this questionnaire prior to your first appointment. Your answers will allow the therapist to have a better understanding of your problem(s). Feel free to ask questions if you need assistance.”*

Today's Date: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street Address) (City, State, Zip Code)

Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_

Gender: Male  or Female  Social Security Number: \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message?  Yes or  No

Work Phone: \_\_\_\_\_ May we leave a message?  Yes or  No

Cell Phone: \_\_\_\_\_ May we leave a message?  Yes or  No

Who referred you to Healing Therapeutic Services? \_\_\_\_\_

Race:  African/American  Asian  Hispanic  Native/American  Caucasian  Other

Are there ethnic/cultural/lifestyle/gender/religious considerations you would like us to be aware of during your care?  
 Yes or  No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

### Section 1 – Relationship Status

\_\_\_\_ Single      \_\_\_\_ Married      \_\_\_\_ Separated      \_\_\_\_ Divorced      \_\_\_\_ Widowed  
\_\_\_\_ Committed Relationship with Significant Other

\* Do you have children?  Yes or  No      \* Do your children live with you?  Yes or  No

Please indicate gender and ages of your children: \_\_\_\_\_  
\_\_\_\_\_

### Section 2 – Residence

\_\_\_\_ Reside Alone      \_\_\_\_ Reside with Parents      \_\_\_\_ Reside with Spouse/Significant Other  
\_\_\_\_ Reside with Roommate(s)      \_\_\_\_ Reside in Foster Care      \_\_\_\_ Reside in Group Home

**Section 3 – Employment History**

Current Employment Status:

- Unemployed       Leave of Absence       Employed Part Time       Employed Full Time
- Student       Temporary Employment

Employer: \_\_\_\_\_

Position / Title: \_\_\_\_\_ Length of Time with Employer: \_\_\_\_\_

**Section 4 - Education**

Please check the highest grade level you completed:

- GED       High School Diploma       BA/BS Degree       Some College Course Work Completed
- Doctorate Degree       AA Degree or 2 Year Program Completion       Other \_\_\_\_\_
- Difficulty Concentrating       Other: \_\_\_\_\_
- Inability to Complete Course Work       Learning Disability – Please explain: \_\_\_\_\_

**Section 5 – Concerns for Yourself**

What are the concerns that cause you to seek our services at this time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check any of the following that apply to yourself:

- Depression       Abuse Issues       Gambling       Panic Attacks       Mood Swings
- Low Self Esteem       Hallucinations       Anger Mgmt       Parenting Concerns
- Suicidal Thoughts / Suicide Attempt(s)       Self Injury       Conflict in Relationships
- Difficulty Concentrating       Sexual Difficulty       Anxiety / Worry / Nervousness
- Alcohol/Substance Abuse/Dependence       Eating Problems/Disorder       Uncomfortable in Social Situation
- Other

**Section 6 – Occupation / Work**

- Conflict with Co-Worker (s)       Conflict with Employer / Supervisor       Poor Work Performance
- Poor Work Performance       Absent / Late       Inadequate Training / Skills       Other



**Section 11 – Medical Information**

Name of primary care physician or medical group: \_\_\_\_\_

Approximate date you last saw your / a physician: \_\_\_\_\_

Please list all the prescription medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

Please list other over the counter medications you regularly take (aspirin, laxatives, vitamins, supplements and herbal remedies): \_\_\_\_\_  
\_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Please check if you have been treated for any of the following:

- High Blood Pressure       Tuberculosis       Diabetes       Stroke       Thyroid Problem
- Meningitis       Heart Problem       Ulcers       Hepatitis       Seizures
- Cancer       Organic Brain Dysfunction

Please list any other medical conditions we should be aware of (surgeries, auto accident injuries, etc): \_\_\_\_\_  
\_\_\_\_\_

**Section 12 – Current / Previous Mental Health Services**

Name of current Psychiatrist / Clinic: \_\_\_\_\_

Name of County Social Worker: \_\_\_\_\_

Prior Psychiatrist: \_\_\_\_\_ Years Treated: \_\_\_\_\_

- Medications: \_\_\_\_\_
- Date of most recent psychiatric hospitalization: \_\_\_\_\_ Hospital Name: \_\_\_\_\_
- Approximate number of psychiatric hospitalizations: \_\_\_\_\_

Prior Therapist: \_\_\_\_\_ Years Treated: \_\_\_\_\_

- Issues: \_\_\_\_\_

If members of your family have been treated for a mental illness, please indicate relationship to you and diagnosis: \_\_\_\_\_  
\_\_\_\_\_

Please list any other background information you feel may be helpful to the therapist in understanding you: \_\_\_\_\_  
\_\_\_\_\_

***Thank you for your time and effort in completing this questionnaire. The information you have provided will be very helpful to us in our effort to treat you and/or your family members.***