Client ID: _____

Suzanne Brown, LCSW, LCAS

CLIENT QUESTIONNAIRE

Please take a few minutes to complete this form. If you have any questions or don't know what to write, please feel free to leave the space blank until we meet.

Today's Date: _____

Information About You:

First Name:	**Middle:**	**Last Name:**
Date of Birth *(mm/dd/yyyy)*:		
Phone Number(s) *(home, cell, work)***:**		
Email:		
❑ **Check here if it's ok for your therapist to call you here** ❑ **Check here if it's ok for your therapist to leave messages here** ❑ **Check here if it's ok for your therapist to email you here**	**Is there anything I need to know about contacting you at this number or email address?**	
Street Address:		
City:	**State:**	**Zip Code:**
Emergency Contact Name:	**Relationship to You:**	
Emergency Contact Phone Number(s):		
Health Care Providers' Name(s)/Phone Number(s):		
Current Medications:		
Have you seen a counselor/therapist in the past? □ Y □ N ***(if yes, please provide the name or agency)***	**Are you currently seeing another counselor/therapist? □ Y □ N** ***(if yes, please provide the name/agency and phone no.)***	

If you have been in counseling or therapy in the past, what was helpful?

What was not helpful?

Age: _____

Gender:

1 Female
2 Male
3 Trans: *[specify* _____*]*
4 Other: *[specify* _____*]*

Ethnic/Cultural Background:

1 African-American
2 American Native/Alaskan Native
2a Tribal Member? □ Y □ N
2b Tribe: _____
3 Asian/Pacific Islander
4 Latino/Latina/Hispanic
5 Mixed Race *[specify*_____*]*
6 White
7 Other: *[specify* _____*]*
8 Country of Origin: *[specify*_____*]*

Primary Religious/Spiritual Orientation:

1 Buddhist
2 Christian
3 Hindu
4 Jewish
5 Muslim
6 Other: *[specify* _____*]*
7 None

Sexual Orientation:

1 Gay
2 Lesbian
3 Bisexual
4 Heterosexual
5 Other: *[specify* _____*]*

Veteran: □ Yes □ No

Disabled: Please list any disability you would like me to know about: _____

Relationship Status:

1 Single
2 Married/Common Law/Domestic Partnership
3 Divorced
4 Widowed
5 Partner/Significant Other
6 Separated

Number of Children *(please circle one)***:**

0 1 2 3 4 5-7 more than 7

Language Spoken in Home:

1 English
2 Spanish
3 Chinese
4 Japanese
5 Other: *[specify* _____*]*

Highest level of education completed:

1 11th grade/under
2 High school diploma/GED/Voc/Tech.
3 Some college or AA degree
4 BA/BS degree
5 Graduate degree

Employment Status:

1 Employed full-time (36 hrs. or more per week)
2 Employed part-time (less than 36 hrs. per week)
3 Unemployed
4 Student
5 Other *[specify* _____*]*

Occupation:_____

Major (if student)**:** _____

Other Information

Who lives in your home, and what is their relationship to you?

	Name	Age	Relationship to you
1			
2			
3			
4			
5			

Please answer each of the following questions. However, feel free to leave blank those questions you do not wish to answer at this time. I may discuss some responses with you.

1	Have you or anyone close to you had recent changes such as job loss, moves, etc.?	□ Yes □ No
2	Have there been any recent deaths or losses in your family or among your friends?	□ Yes □ No
3	Are you or anyone close to you currently dealing with medical concerns?	□ Yes □ No
4	Has any aspect of your life or those around you ever been negatively impacted due to your use of alcohol or other drugs, including prescription medication and supplements?	□ Yes □ No
5	Has anyone ever expressed a concern about your use of alcohol or other drugs, including prescription medication and supplements?	□ Yes □ No
6	Are you now or have you ever been negatively impacted by someone else's use of alcohol or drugs, including prescription medications and supplements?	□ Yes □ No
7	Has any aspect of your life or those around you ever been negatively impacted due to the amount of time you spend on screens, gaming, working, engaging in sexual activities, looking at pornography, gambling, and/or spending money? (if yes, please circle all that apply)	□ Yes □ No
8	Has anyone ever expressed a concern about the amount of time you spend on screens, gaming, working, engaging in sexual activities, looking at pornography, gambling, and/or spending money? (if yes, please circle all that apply)	□ Yes □ No
9	Are you now or have you ever been negatively impacted by someone else's time spent on screens, gaming, working, engaging in sexual activities, looking at pornography, gambling, and/or spending money? (if yes, please circle all that apply)	□ Yes □ No
10	Do you have any concerns with your current nutrition, exercise patterns, or body type?	□ Yes □ No
11	Are you currently or have you ever utilized self-harming behaviors (i.e., cutting yourself, banging your head, burning yourself) as a means of an emotional release or punishment, or for other reasons?	□ Yes □ No
12	Are you currently or have you ever experienced suicidal thoughts (i.e. I don't want to be here anymore, I can't take this anymore, they would be better off without me, I wish I were dead, etc.)?	□ Yes □ No
13	Have you ever heard or seen things other people around you did not? (i.e. hallucinations)	□ Yes □ No
14	At any time during your childhood were you physically harmed?	□ Yes □ No
15	At any time during your childhood did you see or hear someone in your household or community being physically harmed?	□ Yes □ No
16	At any time during your childhood did you live with someone experiencing mental illness or problem substance use?	□ Yes □ No

17	Have you ever been emotionally mistreated in a significant and ongoing way, such as being told you were ugly or stupid, being neglected, or being restricted from activities that are very important to you?	□ Yes □ No
18	Have you ever been made to have some form of unwanted sexual contact?	□ Yes □ No
19	Have you at any time felt afraid due to behavior by an intimate partner (e.g., spouse, boyfriend, girlfriend)?	□ Yes □ No

20 Are you experiencing any difficulties in the following areas *(please check all that apply)*:

□ Alertness	□ Depression/Sadness	□ Pain management
□ Appetite	□ Dizziness/Faintness	□ Sexual problems
□ Body image concerns	□ Headaches	□ Sleep
□ Breathing	□ Memory	□ Stomach pains
□ Concentration	□ Nightmares	□ Stress management/Anxiety
□ Conflict in current relationship	□ Numbness	□ Weight loss or gain

Children in Therapy

Please list all minor children (under 18) who will be participating in therapy with you:	**I have the legal right to give permission for therapy services, because my relationship to the child is (check one):**	**Name of Child's School:**
	❒ Custodial parent ❒ Legal guardian ❒ DHS or OYA caseworker	
	❒ Custodial parent ❒ Legal guardian ❒ DHS or OYA caseworker	
	❒ Custodial parent ❒ Legal guardian ❒ DHS or OYA caseworker	
	❒ Custodial parent ❒ Legal guardian ❒ DHS or OYA caseworker	
	❒ Custodial parent ❒ Legal guardian ❒ DHS or OYA caseworker	
	❒ Custodial parent ❒ Legal guardian ❒ DHS or OYA caseworker	

I Want To Understand The Following About You...

Please describe your reason for seeking therapy at this time:

Who is involved and/or aware of these factors in your life?

Whatever your reason(s) for seeking counseling, how long has this influenced you/your life?

What have you tried to do to resolve these matters on your own? In what way(s) was this helpful?

What are your thoughts about how I might be of help?

Anything else I should know about you?

How were you referred to me? (please check)

Suzanne Brown Resources Website _____ Satir Systems Website _____ Psychology Today Profile _____

Treatment Facility (please list) _____ Another Therapist (please list name) _____

Somewhere Else (please list) _____

Thank you for taking the time to fill this out.