Freedom to Live Counseling
7025 Tall Oak Drive
Colorado Springs, CO 80919
719-233-4776

Client Questionnaire

Name:_____Date:_____

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as possible.

What are your goals for counseling?

Have you seen a mental health professional before? (circle one) Yes No

List all medications and supplements you are presently taking and for what reason.

If taking prescription medication, who is your prescribing MD? Please include type of MD, name, and phone number.

Who is your primary care physician? Please include type of MD, name, and phone number.

Do you drink alcohol? (circle one) Yes No

Do you use recreational drugs? (circle one) Yes No

Do you have suicidal thoughts? (circle one) Yes No

Have you ever attempted suicide? (circle one) Yes No

Do you have thoughts or urges to harm others? (circle one) Yes No

Have you ever been hospitalized for a psychiatric issue? (circle one) Yes No

Is there a history of mental illness in your family? (circle one) Yes No

If you are in a relationship, please describe the nature of the relationship and months or years together.

Describe your current living situation. Do you live alone, with others, with family? etc.

What is your level of education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it?

Please check any of the following you have experienced in the past six months

_____Increased appetite
_____Decreased appetite
_____Trouble concentrating
_____Difficulty sleeping
_____Excessive sleep
_____Low motivation
_____Isolation from others
_____Fatigue/low energy
_____Low self-esteem
_____Depressed mood
_____Tearful or crying spells
_____Anxiety
_____Fear
_____Hopelessness
_____Panic
Other:_____

Please check any of the following that apply
_____Headache
_____High blood pressure
_____Gastritis or esophagitis
_____Hormone-related problems
_____Head injury
_____Angina or chest pain Irritable bowel D Chronic pain
_____Loss of consciousness Heart attack

_____Bone or joint problems
_____Seizures
_____Kidney-related issues
_____Chronic fatigue
_____Dizziness
_____Faintness
_____Heart valve problems
_____Urinary tract problems
_____Fibromyalgia
_____Numbness & tingling
_____Shortness of breath
_____Diabetes
_____Hepatitis
_____Asthma
_____Arthritis
_____Thyroid issues HIV/AIDS
_____Cancer
_____Other:_____