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Licensed Professional Clinical Counselor #LPCC208
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CONFIDENTIAL QUESTIONNAIRE

Please print out this form and fill it out as completely as you like in your own handwriting.
(Skip anything that doesn't apply to you or you're uncomfortable sharing right now.)

How did you hear about us? _____ May we thank them? _____

Name: _____

Date of Birth:_____ Place of Birth: _____ Age: ____ Gender: _____

Address: _____

_____

Tel. Home: _____ Work: _____ Cell: _____

Email: _____

Special Calling Instructions: _____

O.K. to Text?_____ O.K. to Email? _____ O.K. to leave Voice Mail?_____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

What are your primary reasons for seeking help at this time?

_____

_____

_____

_____

_____

What would you like to achieve in therapy (goals)?

_____

_____

What do you expect from treatment?_____

_____

Have you ever been in therapy/mental health treatment? _____

Approx. age/year: _____ Treatment Type: _____Duration: _____

Reason/Outcome:_____

Approx. age/year: _____ Treatment Type: _____Duration: _____

Reason/Outcome:_____

Approx. age/year: _____ Treatment Type: _____Duration: _____

Reason/Outcome:_____

Are you currently receiving any type of mental health treatment? _____ Type: _____

Name of Therapist: _____

Have you ever had EMDR or hypnosis before? _____ Results: _____

_____

Do you know anyone else who has? _____ Results: _____

_____

Have you had other treatments for mental health? _____ Type & results:_____

_____

Family

Relationship Status: _____ Current Other's Name: _____

Living Situation: _____

Participating Others (e.g. co parent, ex wife/husband, in-laws, etc.) :_____

_____

Birth Children # _____Names & ages: _____

_____

Step/Adapted Children # _____Names & ages: _____

_____

Full Siblings # _____Names & ages: _____

_____

Step/Half/Adapted Siblings # _____Names & ages: _____

_____

Family (cont.)

Mother's Name (birth/adaptive): _____Age: _____ Living? _____

Her Partner (If not birth/adaptive father): _____Age: _____ Living? _____

Father's Name (birth/adaptive): _____Age: _____ Living? _____

His Partner (If not birth/adaptive mother): _____Age: _____ Living? _____

Other Significant Caregiver: _____Age: _____ Living? _____

Other Significant Caregiver: _____Age: _____ Living? _____

Career/Work Environment

Education: _____ Fields of interest: _____

Occupation: _____

Do you enjoy your work? _____Want a different job? _____ If so, why? _____

_____

Work place or school difficulties: _____

_____

Other Aspirations: _____

_____

Hobbies, Leisure activities: _____

_____

Military

Have you ever served in the military?_____ Describe: _____

_____

Are you currently on active duty? _____ Describe: _____

_____

Were you ever deployed? _____

Describe your deployment and any issues that arose for you during or after deployment:_____

_____

_____

Legal

Are you involved in any kind of litigation or legal dispute? _____ Describe: _____

_____

Have you ever been arrested or in jail? _____ Describe: _____

_____

Have you ever been court ordered into therapy? _____ Describe: _____

_____

Does someone currently have a restraining order against you? _____ Who? _____

Do you currently have a restraining order against someone? _____ Who? _____

Are there any active cases against you ? _____ Describe: _____

_____

Medical Information

Do you exercise? _____ How often? _____ What type? _____

Do you drink caffeine? _____ How much? _____

Do you smoke? _____ How much? _____

Do you drink alcohol? _____ How much? _____

Do you use Cannabis? _____ How much? _____

Do you use "Recreational" drugs? _____ What & how often? _____

Current or past substance abuse or behavioural addiction issues? ___ Yes ___ No

Describe: _____

Are you currently taking any supplements? ___ Yes ___ No

Please list: _____

_____

Are you currently under the care of a physician? ___ Yes ___ No

If yes, reason? _____

_____

Medical Information (cont.)

Do you have any medical issues (Heart problems, blood pressure, diabetes, etc)? ___ Yes ___ No

Please list: _____

_____

Are you currently taking any medications? ___ Yes ___ No

Please list: _____

_____

Are you currently taking any psychiatric medications? ___ Yes ___ No

Please list: _____

_____

List past medications including psychiatric medications:

_____

_____

Have you ever been given a psychiatric/psychological diagnosis?
(ADHD, PTSD, depression, anxiety, Bi-Polar, Schizophrenia, etc.)? ___ Yes ___ No

Please list: _____

_____

Have you ever been hospitalized for mental/emotional reasons?
(for depression, anxiety, Bi-Polar, Schizophrenia, etc.) ___ Yes ___ No

Please explain: _____

_____

Have you ever had severe depression, anxiety, or panic attacks? ___ Yes ___ No

Please explain: _____

Have you ever attempted or seriously considered suicide? ___ Yes ___ No

Please explain: _____

Are you currently having thoughts of ending your life? ___ Yes ___ No

Please explain: _____

Do you have any type of epilepsy? ___ Yes ___ No

Medical Information (cont.)

Have you recently seen a physician or health professional? ___ Yes ___ No

Reason: _____

Do you have any medical/physical limitations? ___ Yes ___ No

Describe: _____

Did a physician or health professional recommend that you try EMDR/hypnosis? ___ Yes ___ No

Name & Profession:_____

Please mention any other useful/important medical information:
(surgeries, injuries, head injuries, illnesses, etc.)

_____

_____

_____

Is there anything else you'd like to add?

_____

_____

_____

_____

Attestation

The above information I have provided herein is true and complete to the best of my knowledge and I have revealed all medical and psychological information that might effect my participation in this program. I understand professional confidentiality will always be maintained including the content and the fact of our therapy sessions except under certain circumstances as mandated or allowed by law, such as the presence of a reasonable suspicion of child or elder abuse or a serious danger to self (i.e. suicide risk) or others.

(See HIPPA disclosures for more exceptions to confidentiality.)

Name Printed: _____ City/State_____

Signature: _____ Date: _____