Client Name: _____
Social Security Number: _____ Date: _____

CLIENT QUESTIONNAIRE

INSTRUCTIONS: PLEASE *ONLY* FILL IN INFORMATION IN INK *ON DAY OF APPOINTMENT*. PLEASE *PRINT* CLEARLY, FILL IN *ALL* INFORMATION AND DO NOT PRINT N/A.

Date:_____ Social Security number:_____

Date of birth:_____Birthplace:_____Age:_____ Gender: male___female____ transgender____ other_____

Relationship status: ☐single ☐engaged to be married ☐married ☐partnered ☐separated ☐divorced ☐remarried ☐widowed ☐cohabitating

Name:_____
(First) (Middle) (Last) (Maiden) (Nickname)-☐ None

Address: _____

City: _____State:_____Zip code:_____

Home phone:_____Cellular phone_____

Mailing address (**if different than home address**):_____
_____☐mailing address is same as home address

I live with (e.g., child):_____

Occupation:_____Job title:_____☐full-time ☐part-time **☐Not employed**

Employer:_____

Address of employment:_____

Phone number at place of employment:_____Duration of current employment:_____

Longest duration of employment in lifetime:_____# of jobs in past 5 years:_____

Highest level of education achieved (please list any degree(s)):_____

In grade school (1-12 grades), my grades were: ☐below average ☐average ☐above average.

I got along well with: ☐teachers ☐classmates ☐neither teachers ☐neither classmates

I am currently attending school to further my education: ☐Yes ☐No ☐Full-time ☐Part-time

I have been or am in the military: Yes _____ No_____ Year(s)_____ Branch_____

I have been in combat: Yes _____ No_____ Year(s)_____ Branch_____

I have emotional problem(s) related to combat, trauma and/or otherwise from the military: Yes___No___N/A____

I have a history of having a legal problem(s)/issue(s) and/or I am currently having a legal problem(s)/issue(s): Yes____No____

Please specify problem(s)/issue(s) and include date(s) of occurrence:_____
_____

Please list any chiropractors, osteopaths, acupuncturists naturopaths you are currently receiving treatment from and length of treatment:_____☐None

Current <u>physical</u> conditions, difficulties, diseases, health problems **(please *DO NOT specify mental health conditions difficulties/ diseases/problems such as anxiety and depression.*):** ☐None

_____
_____
_____

Check any of the following you have had and specify age when first diagnosed with illness/condition: ☐None

	Age		Age		Age
☐ Acid Reflux	_____	☐ Emphysema	_____	☐ Jaundice	_____
☐ AIDS	_____	☐ Epilepsy	_____	☐ Kidney Disease	_____
☐ Anemia	_____	☐ Fibromyalgia	_____	☐ Liver Disease	_____
☐ Arthritis	_____	☐ Hay Fever	_____	☐ Multiple Sclerosis	_____
☐ Asthma	_____	☐ Head injury	_____	☐ Pancreatitis	_____
☐ Cancer	_____	☐ Heart Disease	_____	☐ Parkinson's Disease	_____
☐ Crohn's Disease	_____	☐ Heart murmur	_____	☐ Rheumatic Fever	_____
☐ Chronic Bronchitis	_____	☐ Hemophilia	_____	☐ Seizure(s)	_____
☐ Systemic Exertion Intolerance Disease	_____	☐ Hepatitis	_____	☐ Stroke	_____
		☐ High Blood Pressure	_____	☐ Meningitis	_____
☐ Chronic pain	_____	☐ HIV+	_____	☐ Thyroid Disease	_____
☐ COPD	_____	☐ Irritable Bowel Syndrome	_____	☐ Tuberculosis	_____
☐ Diabetes	_____			☐ Ulcerative Disease	_____

☐ Traumatic Brain Injury (please specify with age)_____
☐ Sexually Transmitted Infections /Diseases (e.g., Herpes) (please specify with age)_____
☐ Other (please specify with age)_____

Client Name: _____
Social Security Number: _____ Date: _____

Financial Status: ☐no financial problem(s) now ☐having financial problem(s) now ☐debt that is not affordable
☐filed for bankruptcy Please specify date when filed for bankruptcy:_____
☐garnished wage(s) now/past ☐collection agency(ies) contacting me now/past ☐repossessing personal item(s) now/past
☐intend to file for bankruptcy; date to file_____ ☐other_____

I am currently pregnant (***please answer even if male***): Yes____No____ Number months pregnant_____

I and/or my spouse/partner/significant other have a fertility problem: Yes____No____ If problem, please specify problem:_____

_____

I have an allergy, sensitivity, or adverse reaction to medication, food, environment, other substance(s): Yes___No___ Please specify:

_____

_____

Current height:_____Current weight:_____ I am: ☐**underweight** by_____lbs ☐**overweight** by_____lbs ☐**obese** ☐neither

Current medication(s) (**including over the-counter medication(s)**, **vitamin(s)**, **supplement(s), herbal**): ☐None

Medication	Dosage	Initially Prescribed Date Or When First Started	Physician (Name) Or Not Prescribed	Current Side Effect(s) **(If none, write: none)**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Reason(s) for taking each medication (e.g., Heart Disease, Thyroid Disease) listed above: ☐N/A

1._____, 5._____, 9. _____,
2._____, 6._____, 10._____,
3._____, 7._____ ,11._____
4._____, 8._____, 12._____

(Please list any other medications with information requested on other side of this sheet of paper.)

My physician's name is:_____☐None locally

General Practitioner _____ Family Practitioner _____ Other (please specify) _____
OB-GYN _____ Internist _____

My physician's full address and telephone number with area code are:_____

_____

Description of present **physical** health: ☐poor ☐fair ☐good ☐excellent ☐other (please specify)_____

_____

List past operation(s); year; hospital(s)/treating physician(s): ☐None

Types Of Operation	Year	Hospital Or Treating Physician

(Please list any other types of operations with information requested on other side of this sheet of paper.)

Client Name: _____
Social Security Number: _____ Date: _____

Biological mother's name: _____ ☐don't know Adoptive mother's name: _____ ☐n/a
Biological father's name: _____ ☐don't know Adoptive father's name: _____ ☐n/a
I never met my: ☐biological mother ☐biological father Reason never met biological parent(s): _____

As a child, I got along with the following family member(s) (e.g., mother): _____
_____ ☐I didn't get along with any family member

As a child, I did not get along with the following family member(s) (e.g., sister): _____
_____ ☐I got along with all family members _____

I was bullied as a child: Yes____No____ Please specify type of bullying with age of occurrence: _____

Family history of nervous and mental illness/disorder(s) (Family consists of biological/adoptive parents, step-parents, siblings, step-siblings, half-siblings, grandparents, step-grandparents, cousins, blood-relative aunts and uncles; foster family; anyone raised with client or who raised client (e.g., people at orphanage).): Yes____ No____

If yes, please list the person (e.g., parent) and type of nervous and mental illness disorder

Person (e.g., mother, father)	Type Of Nervous/Mental Illness Disorder

Family history of suicide attempt(s) (Family consists of biological/adoptive parents, step-parents, siblings, step-siblings, half-siblings, grandparents, step-grandparents, cousins, blood-relative aunts and uncles; foster family; anyone raised with client or who raised client (e.g., people at orphanage).): Yes____ No____

If yes, please list the person (e.g., mother, father) and means of suicide attempt (e.g., pills)

Person (e.g., mother, father)	Means Of Suicide Attempt (e.g., pills)

Family history of homicide attempt(s) (Family consists of biological/adoptive parents, step-parents, siblings, step-siblings, half-siblings, grandparents, step-grandparents, cousins, blood-relative aunts and uncles; foster family; anyone raised with client or who raised client (e.g., people at orphanage).): Yes____ No____

If yes, please list the person (e.g., mother, father) and means of homicide attempt (e.g., gun)

Person (e.g., mother, father)	Means of Homicide Attempt (e.g., gun)

I have a history of **suicide** attempt(s): Yes____ No____

If yes, please list date(s), age(s), means of suicide attempt (e.g., pills)

Date	Age	Means (e.g., pills)

I have a history of **homicide** attempt(s): Yes____No____

If yes, please list date(s), age(s), means of homicide attempt (e.g., gun)

Date	Age	Means (e.g., gun)

Client Name: _____
Social Security Number: _____ Date: _____

I have received and/or I am currently receiving treatment from a **professional** psychiatrist, psychologist, counselor, marriage counselor, social worker, other mental health professional and/or have had a psychiatric hospital admission(s) and/or have been in a hospital for mental/nervous problem(s):

Yes_____ No_____ I am currently receiving mental health treatment: Yes____No_____

If yes to either of the yes responses, please list **all** services received/receiving and fill in **all** information. If you do not know the information, write: don't know

1. Date of service:_____

   Type of professional (e.g., counselor):_____

   Name of professional/hospital:_____

   Length of treatment:_____

   Frequency of treatment (e.g., once weekly):_____

   Reason for treatment:_____

   _____

   Quality of services (e.g., excellent, good, fair, poor):_____

   Treatment was/is helpful: Yes_____ No_____ Diagnosis(es) was/is:_____

   For the most part, I followed the professional's advice/suggestions: Yes_____ No_____

2. Date of service:_____

   Type of professional (e.g., counselor):_____

   Name of professional/hospital:_____

   Length of treatment:_____

   Frequency of treatment (e.g., once weekly):_____

   Reason for treatment:_____

   _____

   Quality of services (e.g., excellent, good, fair, poor):_____

   Treatment was/is helpful: Yes_____ No_____ Diagnosis(es) was/is:_____

   For the most part, I followed the professional's advice/suggestions: Yes_____ No_____

3. Date of service:_____

   Type of professional (e.g., counselor):_____

   Name of professional/hospital:_____

   Length of treatment:_____

   Frequency of treatment (e.g., once weekly):_____

   Reason for treatment:_____

   _____

   Quality of services (e.g., excellent, good, fair, poor):_____

   Treatment was/is helpful: Yes_____ No_____ Diagnosis(es) was/is:_____

   For the most part, I followed the professional's advice/suggestions: Yes_____ No_____

Client Name: _____
Social Security Number: _____ Date: _____

4. Date of service: _____

   Type of professional (e.g., counselor): _____

   Name of professional/hospital: _____

   Length of treatment: _____

   Frequency of treatment (e.g., once weekly): _____

   Reason for treatment: _____

   _____

   Quality if services (e.g., excellent, good, fair, poor): _____

   Treatment was/is helpful: Yes_____ No_____ Diagnosis(es) was/is: _____

   For the most part, I followed the professional's advice/suggestions: Yes_____ No_____

5. Date of service: _____

   Type of Professional (e.g., counselor): _____

   Name of professional/hospital: _____

   Length of treatment: _____

   Frequency of treatment (e.g., once weekly): _____

   Reason For Treatment: _____

   _____

   Quality of services (e.g., excellent, good, fair, poor): _____

   Treatment was/is helpful: Yes_____ No_____ Diagnosis(es) was/is: _____

   For the most part, I followed the professional's advice/suggestions: Yes_____ No_____

6. Date of service: _____

   Type of professional (e.g., counselor): _____

   Name of professional/hospital: _____

   Length of treatment: _____

   Frequency of treatment (e.g., once weekly): _____

   Reason for treatment: _____

   _____

   Quality of services (e.g., excellent, good, fair, poor): _____

   Treatment was/is helpful: Yes_____ No_____ Diagnosis(es) was/is: _____

   For the most part, I followed the professional's advice/suggestions: Yes_____ No_____

(Please list any additional dates of service on back of this sheet of paper.)

I attend a support group(s): Yes____No_____ Type of support group(s) (e.g., AA; cancer): _____

_____

I have a history of treatment for alcohol, drugs(s), prescription abuse/dependence and/or substance use disorder(s) (including but not limited to tobacco and caffeine, illegal drug(s)): Yes_____No_____ Date(s): _____

Treatment for (e.g., alcohol): _____

I had: ☐detox ☐outpatient ☐inpatient ☐aftercare ☐other (please specify)_____

_____

_____

Client Name: _____

Social Security Number: _____ Date: _____

Please Check Appropriate Category For Each SYMPTOM You Are CURRENTLY Experiencing	None	Mild	Moderate	Severe
1. Worry				
2. Anxiety				
3. Restlessness				
4. Keyed Up				
5. On The Edge				
6. Easily Fatigued				
7. Difficulty Concentrating				
8. Mind Goes Blank				
9. Irritability				
10. Muscle Tension				
11. Sleep Disturbance				
12. Sleeping More Than 10 Hrs. Daily				
13. Sleeping Less Than 6 Hrs. Daily				
14. Intermittent Awakening				
15. Difficulty Falling Asleep				
16. Early Awakening				
17. Heart Palpitations				
18. Pounding Heart				
19. Accelerate Heart Rate				
20. Sweating				
21. Trembling				
22. Shaking				
23. Chills				
24. Hot Flashes				
25. Smothering Sensations				
26. Shortness Of Breath Sensations				
27. Feelings Of Choking				
28. Chest Discomfort/Pain				
29. Abdominal Distress				
30. Nausea				
31. Tingling Sensations				
32. Numbness				
33. Dizziness				
34. Feeling Unsteady				
35. Feeling Faint				
36. Feeling Lightheaded				
37. Fear Of Losing Control				
38. Fear Of Going Crazy				
39. Feelings Of Unreality				
40. Feelings Of Being Outside Of One's Body/Detached From One's Self				
41. Short Attention Span				
42. Difficulty Completing Tasks				
43. Excessive Daydreaming				
44. Easily Distracted				
45. Excessive Talking				
46. Engages In Much Activity But Accomplishes Little				
47. Difficulty Listening				
48. Excessively Shifts From One Activity To Another				
49. Easily Frustrated				

Please Check Appropriate Category For Each SYMPTOM You Are CURRENTLY Experiencing	None	Mild	Moderate	Severe
50. Dislikes Situations Which Require Being Still And Paying Attention				
51. Poor Appetite				
52. Unintentional Weight Gain Of Greater Than 10 Pounds In Past 30 Days				
53. Unintentional Weight Loss Of Greater Than 10 Pounds In Past 30 Days				
54. Overeating				
55. Low Energy				
56. Low Self-Esteem				
57. Fatigue				
58. Poor Concentration				
59. Difficulty Making Decisions				
60. Feelings Of Helplessness				
61. Feelings Of Hopelessness				
62. Crying Spells				
63. Social Isolation				
64. Agitated				
65. Diminished Interest In Usual Activities				
66. Recurrent Thoughts Of Death				
67. Suicidal Thoughts				
68. Homicidal Thoughts				
69. Feelings Of Worthlessness				
70. Guilt				
71. Violent Behavior				
72. Feelings Of Emptiness				
73. Poor Relationships				
74. Anger				
75. Hostility				
76. Phobias				
77. Reliving Life Events As If **Actually** Feeling Back In Time				
78. Self-Mutilation (i.e. Cut On Self)				
79. Sexual Problems				
80. Paranoia				
81. Obsessions				
82. Compulsive Behavior				
83. Excessive Spending				
84. Inflated Self-Esteem/Grandiose				
85. Racing Thoughts				
86. Decreased Need For Sleep				
87. Feels Pressure To Keep Talking More Than Usual				
88. Difficulty Functioning At Home				
89. Difficulty Functioning Socially				
90. Difficulty Functioning At Work				
91. Difficulty Functioning At School				
92. Hears Voices Within The Head				
93. Fearfulness				
94. Lawbreaking				
95. Conflict With Authority				

Client Name:_____
Social Security Number:_____ Date:_____

Current Stress:

Occupational problem(s) _____
Problem(s) with family _____
Housing problem(s)
Educational problem(s) _____
Economic problem(s) _____
Environmental problem(s) _____
Parenting problem(s) _____
Other problem(s) (please specify)_____

Problem(s) with legally married spouse _____
Problem(s) with significant other (not spouse) _____
Problem(s) with social relationships outside of family _____
Problem(s) with crime or the legal system _____
Problem(s) with access to health care _____
Physical illness or Injury _____

The stress is (please circle one): Mild Moderate Severe Extreme Catastrophic

Please explain any stress noted above:_____

Reason(s) for seeking counseling today:_____

Please specify ***ONLY*** **THE ENTITY WHO REFERRED YOU** specifically to Barbara E. Kaplan, MHDL for counseling or where obtained her name:

Family Member_____ Friend_____ Employer_____ Boss_____ Co-Worker_____ Court_____ Self _____

Physician (please specify)_____ _____

Attorney (please specify)_____ _____

Employee assisted program (please specify)_____ _____

Insurance company (please specify)_____ _____

Advertisement (please specify if in print and/ or online and where viewed)_____ _____

Other (please specify)_____ _____

I was told by my employer, manager, supervisor and/or human resources to attend counseling:
Yes_____No_____ Reason told to attend:_____

***Gross* family income or *gross* combined partner/souse income (to determine counseling fee):**

Less than $50,000.00 a year_____ $50,000.00 a year or more_____

Client Name:_____

Social Security Number:_____ Date:_____

In addition to those circumstances under which information may be released as listed in the Disclosure Statement that I have signed, Barbara E. Kaplan, MHDL has my permission, in case of an emergency, to contact the following person(s), inform them of the emergency and that I am in counseling (if possible, please list person(s) who lives *locally)*:

1 Person:_____

Relationships to client (e.g., parent):_____

Address: _____

_____

_____

Telephone number(s): home _____ work _____ cell _____

2 Person:_____

Relationships to client (e.g., parent):_____

Address: _____

_____

_____

Telephone number(s): home _____ work _____ cell _____

In addition to those circumstances under which information may be released as listed in the Disclosure Statement that I have signed, Barbara E. Kaplan, MHDL has my permission, in case of my death, to release my name, that I was in counseling, that Barbara E. Kaplan, MHDL provided the counseling, and the name(s) of my next of kin(s) to police and/or emergency personnel (e.g., emergency technician or EMT; ambulance technician(s)) (Next of kin is defined as a person's closest living blood relative or relative):

1 Name of kin:_____

Address: _____

_____

Telephone number(s): home _____ work _____ cell _____
Relationships to client (e.g., parent):_____

2 Name of kin:_____

Address: _____

_____

Telephone number(s): home _____ work _____ cell _____
Relationships to client (e.g., parent):_____

I have filled in this Client Questionnaire truthfully and to the best of my ability. I give my permission to Barbara E. Kaplan, MHDL **to contact me during the term of counseling and after counseling has terminated (for a period of 1 year)**: (1) at any telephone number listed on Page 1 of this Client Questionnaire and/or any other telephone number(s) I specify in writing, (2) at any telephone number(s) I specify when leaving a message and/or when I specify it in writing (3) by forwarding correspondence to my home and/or mailing address listed on Page 1 of this Client Questionnaire and any other address(es) I specify verbally and/or in writing to forward correspondence to me. The **correspondence may include *but not be limited to*: billing and letter(s) regarding appointment(s), scheduling an appointment(s),**

Client Name:_____
Social Security Number:_____ Date:_____

termination of treatment, physical health, mental health diagnosis(es), physical diagnosis(es), provisional mental health diagnois(es), mental health, mental health treatment, substance use, alcohol use, drug use, mental health impairment(s), psychological and psychiatric impairment(s), gene-related impairment(s) (including genetic testing and genetic test result(s)), developmental disability(ies), any disability(ies), sexually transmitted disease(s), Sickle cell anemia, Human Immunodeficiency Virus (HIV), Human Immunodeficiency Virus antibody status (HIV antibody status), Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex (ARC), HIV infection(s), AIDS-related conditions, and any other medical condition(s)/communicable disease(s). Information specified in correspondence may be sensitive information. If the US Postal Service has specified a new address to contact me, Barbara E. Kaplan, MHDL has my permission to forward correspondence to me at this new address. Barbara E. Kaplan, MHDL also has my permission to leave a message(s) **during the term of counseling and after counseling has terminated (for a period of 1 year)** when calling: (1) any telephone number listed on page 1 of this Client Questionnaire and/or any other telephone number(s) I specify in writing and (2) any telephone number(s) I specify when leaving a message. If when calling any of these telephone numbers, there is a recorded message by a telephone company and/or client and/or other person specifying a change to a different telephone number, Barbara E. Kaplan, MHDL has my permission to contact me at this different telephone number and has my permission to leave a message(s) at this different telephone number. Barbara E. Kaplan, MHDL has my permission to contact me in writing or by telephone at any time after counseling has been terminated **even beyond a year** if there is money owed on my account and/or claims have not been satisfied with respect to my counseling and/or if there is a legal and/or ethical obligation for her to meet with respect to me (and/or any collateral who participated in the counseling process) and/or there is a request for the release of the client record in whole or in part. **A phone message(s) from Barbara E Kaplan, MHDL for me *and* phone conversation(s) between Barbara E. Kaplan, MHDL and me may include *but not be limited to:* billing and letter(s) regarding appointment(s), scheduling an appointment(s), termination of treatment, physical health, mental health diagnosis(es), physical diagnosis(es), provisional mental health diagnosis(es), mental health, mental health treatment, substance use, alcohol use, drug use, mental health impairment(s), psychological and psychiatric impairment(s), gene-related impairment(s) (including genetic testing and genetic test result(s)), developmental disability(ies), any disability(ies), sexually transmitted disease(s), Sickle cell anemia, Human Immunodeficiency Virus (HIV), Human Immunodeficiency Virus antibody status (HIV antibody status), Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex (ARC), HIV infection(s), AIDS-related conditions, and any other medical condition(s)/communicable disease(s). Information released in phone message(s) and phone conversation(s) may be sensitive information. I understand that there may be instances (such as no readily available landline telephone for Barbara E. Kaplan, MHDL to use), when the telephone operator from her answering service may tell me a message from Barbara E. Kaplan, MHDL. An example of a message from the operator may be that Barbara E. Kaplan, MHDL is at a seminar and will call me in the evening and wants to know the phone number of clients to return calls in evening.** ***I understand that cellular telephone conversations may be overheard and therefore are not confidential and that if I choose to speak with Barbara E. Kaplan, MHDL using a cellular telephone (even if she called me dialing my cellular telephone number), then I assume the risk and responsibility, not her, of person(s) hearing the conversation(s) who are not intended to hear the conversation(s) that may contain sensitive and/or nonsensitive information. I understand that Barbara E. Kaplan, MHDL requests that telephone calls be made from a landline telephone to avoid this risk and responsibility.***

Name of Client (Please Print)	Signature of Client or Guardian	Date Signed
Name of Person Filling Out This Form If Other Than Client (Please Print)		Date Signed
Barbara E. Kaplan, MHDL Name of Witness	Signature of Witness	Date Signed