**PROFESSIONAL COUNSELING AND BIOFEEDBACK CENTER**
**ADULT CLIENT QUESTIONNAIRE**

Date: _____
(Mr/Ms/Mrs)_____ Name: _____
Nickname/preferred_____DOB: _____ Age: _____

What difficulties brought you here today?
_____
_____
_____

## SYMPTOMS

In the past month I have been/had:

__ sadness
__ tearfulness
__ sleep difficulty
__ appetite problems
__ difficulty concentrating
__ memory problems
__ lack of interest
__ activity withdrawal
__ headaches
__ stomach upset
__ suicidal thoughts
__ homicidal thoughts
__ sexual abuse/assault
__ legal problems
__ defiance
__ spiteful/vindictive thoughts
__ worrying
__ shakiness/trembling
__ racing heart
__ sweating/flushes/chills
__ dizziness/nausea
__ tiredness
__ irritableness/on edge
__ insecurity
__ mistrust
__ bowel problems
__ asthma/allergies
__ nervousness
__ school problems/truancy
__ hopeless/helpless
__ anger/frustration
__ loneliness
__ moodiness
__ fears/phobia
__ uncontrollable thoughts
__ uncontrollable behaviors
__ relationship problems
__ family problems
__ issues of loss/grief
__ stress
__ difficulty relaxing
__ work problems
__ overspending
__ legal problems
__ easily annoyed
__ argumentative
__ used alcohol
__ taken drugs
__ hostile
__ health concerns

## SELF – HURTFUL BEHAVIORS

Do you have thoughts of hurting yourself or someone else? _____
If so, explain: _____

Have you ever attempted suicide? _____ Explain_____
_____
_____
_____

## HEALTH HISTORY

Current Physician _____ If under 18, are immunizations current _____

Were You Referred To Us? _____ Referred by: _____

Medications currently taking _____
_____

Allergies_____
_____

What health problems are you having? _____
_____

Do you smoke? _____ If so, how much a day? _____

Which alcoholic beverages do you prefer? _____

Where do you usually drink and with whom? _____

How many drinks per day? _____ week? _____ month? _____

Do you use drugs? _____ If so, what and how frequently? _____

Do you want to change your drug use? _____

**PREVIOUS TREATMENT**

Have you received counseling before? Yes_____ No_____

Name of Therapist or Hospital: When:
_____ _____
_____ _____

**DEVELOPMENTAL AND FAMILY HISTORY**

Mother's Name_____

( ) living, age _____ ( ) deceased, cause of death _____

City where she lives_____ Occupation_____

Father's Name_____

( ) living, age _____ ( ) deceased, cause of death _____

City where he lives _____ Occupation _____

| Name of brothers/sisters | Age | Occupation | City |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**EDUCATION HISTORY**

Highest grade or degrees completed: _____

Where: _____ Major field: _____

List any significant events relating to school or childhood hobbies: _____
_____

Have you ever been abused sexually, physically or emotionally? _____
If yes, please explain: _____
_____

**EMPLOYMENT HISTORY**

*Employer:* _____

Job Title: _____ How long? _____

Describe any work related problems: _____

What are your future career goals? _____

If in current job less than 5 years, what was your previous job? _____

How long? _____ Why did you terminate the job? _____

**MARITAL HISTORY**

*Presently: Married ____ Single____ Divorced ____ Separated ____ Widowed ____ Engaged ____*

| *Dates of beginning* and end of marriage(s) (beginning with your first marriage) | To Whom | # of children born or adopted in this marriage | Reason for end of marriage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Spouse's Name: _____ Age_____

Spouse's Occupation_____

How often do you and your spouse go out socially? Per week _____ Per month _____

Who is the dominant member of your relationship? You _____ Spouse _____

List some of the behaviors of your spouse that you like:

_____

List some of the behaviors of your spouse that you don't like:

_____

List children that live in your household.

| Name (first, last) | Age | Natural parent |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

List the children of you or your spouse who does not live in your household.

| Name (first, last) | Age | Natural parent |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

List the other people who currently live in your household and their relationship to you.

| Name | Relationship |
| --- | --- |
| | |
| | |
| | |

**RELIGIOUS ACTIVITY**

Do you presently engage in any religious activity? ( ) yes ( ) no

If so, please describe: _____

_____

**SOCIAL/RECREATION**

What do you do for entertainment and fun? With whom and how often?

_____ _____

_____ _____

Do you belong to any clubs or volunteer organizations? If so, which ones.

_____

**PERSONALITY DESCRIPTION**

Describe the sort of person you are: _____

_____

_____

_____

_____

Client Signature: _____

Date: _____