NEW CLIENT QUESTIONNAIRE

Trevor Walton, MMFT

Masters in Marriage and Family Counseling

COUNSELING FOR COUPLES, FAMILIES & INDIVIDUALS

615-422-5953 | Trevor@hoperestorednashville.com | hoperestorednashville.com

Today's Date _____ Referred by _____

Name(s) _____ Spouse/Other _____

Occupation _____ Spouse/Other Occupation _____

Phone Number (where you prefer to be contacted) _____ Spouse/Other Phone _____

Street Address _____ Spouse/Other Street Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Date of Birth _____ Spouse/Other Date of Birth _____

E-mail address(es) _____

Marital Status: O Single O Engaged O Married O Separated O Divorced O Remarried

List members of your family and/or all others living in your home:

Name	Sex	Age	Relationship to you
Name	Sex	Age	Relationship to you
Name	Sex	Age	Relationship to you
Name	Sex	Age	Relationship to you

Briefly describe your reason for seeking help:_____

_____

When were you last examined by a physician?

Name of physician:_____ Phone Number:_____

List any major health problems for which you currently receive treatment:

List all medications you are now taking:

Have you received psychiatric or psychological treatment or counseling before? O Yes O No

If yes, please give name(s) of provider(s), location(s) and treatment dates: _____

_____

Please check all that apply to you:
(If attending therapy as a couple, please check each symptom as it applies to you individually)

O Depression
O Loss/Grief Issues
O Drug/Alcohol Use
O Anger/Rage
O Pornography
O Self-worth
O Financial Concerns
O Sexual Struggles
O Suicidal Thoughts
O Stress
O Anxiety/Fears
O Divorce or Separation
O Eating Disorder
O Body Image/Weight Concerns
O Sleep Problems
O Loneliness
O Marital Struggles
O Premarital Concerns
O History of Abuse
O Parenting Struggles
O Lack of Concentration
O Headaches/Other Pain
O Problems at Work/School
O Health Concerns
O Friendship Struggles
O Spiritual Concerns
O Struggles with: (circle) Pregnancy, Infertility, Miscarriage, Postpartum Depression
O Adoption Preparation and Concerns (Pre and Post Adoption)
O Compulsive/Addictive Behavior (Sex, Shopping, Gambling, Risk Taking, etc.)

O Other: _____

Regarding the items you checked above, use the space below to list the item(s) on which you would most like to focus your therapy. Then rate each one (where applicable) on its level of disturbance to you using a scale from 0 (no disturbance) to 10 (high disturbance). “Disturbance” can relate to how much it bothers you or impacts your daily functioning. (Example: Depression - 10, Body Image - 8)

It is important for the client and therapist to agree on a course of therapy and types of interventions that best fit the client's individual personality and goals for therapy. Your answers in the following questions help me learn more about you and understand your view of therapy and commitment to the process:

In a few words, what do you think therapy is all about?

How long do you think therapy should last? How long are you able to commit to therapy?

What personal qualities do you think the ideal therapist should possess?

What types of self-care practices have been helpful to you in the past when dealing with difficult situations? These may be things you learned from previous therapy or discovered on your own. Examples: journaling, exercising, workbooks, prayer, support groups.

What are some of your hobbies/interests?

I have/will read the Counseling Policies provided to me to review, and I agree to abide by the terms.

Signature of responsible party _____ *Date* _____