JILL L. KOFENDER, PHD, PLLC

Licensed Clinical Psychologist

ADULT CLIENT QUESTIONNAIRE

Client's Name_____ Today's Date_____
Gender_____ Age_____ Birthdate_____

Cell Phone_____ Is it ok to text? Y N
Is it ok to receive appt. reminders? Y N
Is it ok to leave a message? Y N

Work Phone_____ Is it ok to leave a message? Y N

Home Phone_____ Is it ok to leave a message? Y N

Email_____ Is it ok to email? Y N

Home Address_____

Who referred you to my office?_____
May I have your permission to thank this person for the referral? Y N

Please describe the main difficulty that has brought you to see me:

_____

_____

_____

What would you like to accomplish by coming here? What are your goals for treatment?

_____

_____
Occupation_____ Part Time____Full Time____
Place of Employment_____
Work Address_____
Highest Education Completed_____
Military History_____

Relationship: Never Married Married Partnered Separated Divorced Widowed
Name of Partner/Spouse_____

Involvement in legal cases at present time? Yes_____ No_____
If yes, please explain_____

Religious affiliation_____Ethnicity/national origin/race_____

Family Members: (Please include parents, children, siblings, spouse/partner)

Name	Age	Relationship to client	Occupation/Grade	Lives w client

Emergency Contact Person_____
Relationship to Client_____
Phone Numbers of Emergency Contact_____

Primary Physician_____ Phone_____
Address_____
_

Are you currently having suicidal thoughts? Yes_____No_____
Have you had suicidal thoughts in the past? Yes_____No_____ If so, when?_____
Have you ever attempted suicide? Yes____ No_____ If so, when?_____
If yes to any of the above, please describe_____
_____

Please list any significant current or previous medical diagnoses, illnesses, injuries or surgeries:

_____

_____

Please list any medications you take or have taken in the past year:

_____

_____

Have you ever received outpatient psychological, psychiatric, drug or alcohol, or counseling services before? Yes_____ No_____
Have you ever received inpatient treatment? Yes_____ No_____

Please describe the services you have received, both outpatient and inpatient:

When For How Long From Whom For What Medications (please list)

_____

_____

_____

Please describe your relationships:

Significant Other_____
Children_____
Siblings_____
Friends_____

Have you ever been physically abused? Y N
Have you ever been sexually abused? Y N
Have you ever been emotionally/psychologically abused? Y N
If yes for any of the above, please describe:
_____
_____

How much and how often do you consume caffeine_____
How much and how often do you use nicotene_____
How much and how often do you drink alcohol_____
Have you ever been told you should cut down on your drinking_____
Have you ever felt guilty about your drinking_____
How much and how often do you use recreational drugs_____
Please list substances used_____

Family History: (Please indicate who and describe)
Substance Abuse_____
Anxiety_____
Depression_____
Bipolar Disorder_____
Schizophrenia_____
Suicide_____

Autism Spectrum_____
Developmental Disability_____
ADHD_____

Checklist Of Your Concerns:
Please circle all areas of concern on this page and the next one. You may also add a note or details in the space next to the circled concerns.

ABUSE
AGGRESSION/VIOLENCE
ALCOHOL USE
ANGER
ANXIETY/WORRY
ATTENTION/CONCENTRATION/DISTRACTIBILITY
BODY IMAGE
CAREER
CHILDHOOD ISSUES
CONFUSION
COMPULSIONS
CUSTODY OF CHILDREN
DECISION MAKING
DELUSIONS (FALSE IDEAS)
DEPENDENCE ON OTHERS
DEPRESSION, SADNESS, CRYING
DIVORCE/SEPARATION
DRUG USE
EATING PROBLEMS, OVEREATING, UNDEREATING, VOMITING
EMPTINESS
FAILURE
FATIGUE
FEARS/PHOBIAS
FINANCIAL PROBLEMS
FRIENDSHIPS
GAMBLING
GENDER IDENTITY
GRIEF/MOURNING
GUILT
HALLUCINATIONS
HEADACHES
HEALTH CONCERNS
INTERPERSONAL CONFLICTS
IMPULSIVITY
IRRITABILITY

LEGAL MATTERS
LONELINESS
MARITAL PROBLEMS
MEMORY
MENSTRUAL PROBLEMS
MOOD SWINGS
NERVOUSNESS
OBSESSIONAL THOUGHTS
PANIC ATTACKS
PARENTING
PREGNANCY/POSTPARTUM
RAPID SPEECH
RELATIONSHIPS
SCHOOL
SELF ESTEEM
SEXUAL ISSUES
SHYNESS
SLEEP
SMOKING
STRESS
SUICIDAL THOUGHTS
TEMPER
WEIGHT/DIET
WITHDRAWAL

Any other issues or concerns?_____
_____

Which is the concern that you most want help with?_____
What do you consider to be your strengths?_____
What do you like most about yourself?_____