Name: _____

Laurie Friesen, LMFT

Client History Questionnaire

1.) Current Symptoms: Please circle any of the following that you have experienced recently.

Anger
Anxiety
Avoid People
Blended Family Issues
Can't Have Fun
Can't Relax
Communication Problems
~~Compulsive Behavior~~
Constipation
Crying Easily
Death of a Loved One
Decreased Sex Drive
Depression
Diarrhea
Dizziness
Dry Mouth
Family Problems
Family Violence
Fearful
Financial Problems
Guilt
Headache
Health Problems
Hearing Voices
Hopelessness
Hyperactivity
Hyperventilation
Impulsive
~~Increased Appetite~~
Indecisiveness
Inferiority
Irritability
Lack of Interest
Loneliness
Low Self-Esteem
Mood Swings
Nightmares
Overly Ambitious
Panic Attacks
Paranoia
Parent-Child Conflict
Personality Changes
Phobias
Physical Abuse
Poor Appetite
Poor Attention Span
Poor Sleep
Relationship Problems
Seeing Things
~~Sexual Abuse~~
Sexual Problems
Shaky Hands
Shaky Inside
Stress
Suicidal Feelings
Tired Easily
Weakness
Weight Gain
Weight Loss
Work Problems
Other _____

2.) Symptoms have been present for: Less than 1 month 1-6 months 7-11 months more than a year

3.) Previous Treatment: Pastoral Counseling Hospital Professional Counseling

Treated for: _____ Treated by: _____

4.) ~~Medical History~~: (previous illness, medications with dose, current physical and family history)

_____

_____

_____

_____

Physician's Name: _____ Date of last physical exam: _____

Permission to Contact YES NO

Raised By: Parents Mother Father Step-mother Step-father Foster Parents Other

Siblings: Number of brothers _____ Number of sisters _____ What number are you? _____

Describe your mother: Kind Pleasant Easy-going Strict Abusive Emotional Problems Addicted

Describe your relationship with your Mother: _____

Describe your father: Kind Pleasant Easy-going Strict Abusive Emotional Problems, Addicted

Describe your relationship with your Father: _____

(PLEASE COMPLETE BOTH SIDES)

5.) **Counseling History:** (please include all prior inpatient and outpatient treatment. Also include response to medications)_____

_____

_____

6.) **Psychiatrist name (if applicable)** _____
Permission to contact? YES NO

7.) **History of Abuse:** Physical By Whom?_____ At What Age?_____
Verbal By Whom?_____ At What Age?_____
Sexual By Whom?_____ At What Age?_____

8.) Marital History: Number of Marriages: _____
First Marriage: Age: _____ Spouse's Age: _____ Duration: _____ # of children: _____
If first marriage ended, for what reason? _____
Second Marriage: Age: _____ Spouse's Age: _____ Duration: _____ # of children: _____
If second marriage ended, for what reason? _____
Additional marriages: _____

9.) **Education:** Highest grade completed _____ Friendships: Many Few Outgoing Withdrawn
10.) **Employment:** Usual _____ Present _____ How long? _____
11.) **Conflicts with the Law:** YES NO As: Child Teen Adult Describe:_____
12.) **Military:** Years in service_____ Rank _____ Vet of which War _____ Seen Action _____
13.) **Habits:** *Alcohol use*: No Socially Rarely Frequently Daily Weekends During day At work
Age you started drinking _____ Do you or anyone else think you have a drinking problem? _____
Drug use: YES NO If yes, what drugs do you use and how often? _____

_____

Food: Overeat Undereat Binge Purge High Sugar Intake
Other habits that negatively impact you: Sex Work Spending Other:_____

14.) **Spiritual Background:**
What is your spiritual background? _____
Attend church? YES NO Name of church:_____

15.) **Additional Comments:** _____

_____

Thank you for your cooperation

_____ _____
Signature of person providing information **Date**

_____
Relationship to client