

Client Background and History Questionnaire

Please complete this questionnaire as accurately as possible. This information is confidential and will help us understand your background to provide the best possible service.

1. Personal Information

Full Name:

Date of Birth (MM/DD/YYYY):

Gender / Identity:

Phone Number:

Email Address:

Street Address:

City, State, Zip Code:

2. Emergency Contact

Contact Person Name:

Relationship to Client:

Contact Phone Number:

3. Family and Social History

Marital / Relationship Status:

Do you have any children? (If yes, please list names and ages):

Who do you currently live with?

Briefly describe your support system (friends, family, community):

4. Educational and Employment History

Highest Level of Education Completed:

Current Employment Status and Occupation:

Are you satisfied with your current career/educational path?

5. Medical and Mental Health History

Please list any current medical conditions or physical illnesses:

Please list any current medications, dosages, and purposes:

Have you ever received mental health counseling or psychiatric services before? (Yes/No, details):

Is there a family history of mental illness or substance abuse? (Please describe):

6. Reason for Seeking Services

What are the main concerns or goals that bring you here today?

When did these concerns first begin to impact your daily life?

What coping strategies or resources have you tried so far?

7. Signature

Client Signature (Printed):

Date Signed (MM/DD/YYYY):