

Jill L. Schram, Ph.D., P.L.L.C.

Licensed Clinical Psychologist

ADULT CLIENT QUESTIONNAIRE (AGES 18+)

Client's Name _____ Date _____ ___ Male ___ Female

If necessary, I give Dr. Schram permission to call me at the following numbers:

Home Phone: _____ OK to leave a message: Y N

Work Phone: _____ OK to leave a message: Y N

Cell Phone: _____ OK to leave a message: Y N

Other: _____ OK to leave a message: Y N

Email: _____ OK to email: Y N

Calls or emails will be discreet, but please indicate any restrictions: _____

Age: _____ Date of Birth: _____

Address: _____

Who referred you to my office: _____

May I have your permission to thank this person for the referral: ___ Yes ___ No

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: _____ Place of Employment: _____

Work Address: _____

Type of Employment: ___ Full-time ___ Part-time

Highest Education Completed: _____

Military History: _____

Relationship: Never Married Married Partnered Separated Divorced Widowed

If Relationship, Name of Partner/Spouse: _____ Age: _____

Involvement in legal cases at present time: ___ Yes ___ No

If yes, please explain: _____

Family Members:

Name	Relationship to client	Age	Occupation/Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Emergency Contact Person: _____

Relationship to Client: _____

Phone of emergency contact: Home _____ Work _____

Primary Physician: _____ Phone _____

Address: _____

Have you ever thought about suicide: ___ Yes ___ No

If yes, when was the last time: _____

What were the circumstances: _____

Have you ever attempted suicide: ___ Yes ___ No

If yes, describe when and how: _____

Are you currently having suicidal thoughts: ___ Yes ___ No

Please list any significant current or previous physical health problems, illnesses, injuries, or surgeries:

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

Religious affiliation: _____

Ethnicity/national origin/race: _____

Have you ever received psychological, psychiatric, drug or alcohol, or counseling services before:

___ Yes ___ No

If yes, please describe:

When	From whom	For what	Medications?(please list)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your relationships with your:

Spouse/Significant Other: _____

Children: _____

Siblings: _____

Friends: _____

Have you ever been abused: ___ Yes ___ No

If yes: ___ Physical ___ Sexual ___ Emotional/Psychological

Please describe: _____

Substance use:

How much and how often do you consume caffeine: _____

How much and how often do you use nicotine: _____

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 of: (If yes, please indicate who and describe)

Substance Abuse: _____

Mental health problems: _____

Suicide: _____

Autism: _____

Developmental Disability: _____

ADHD: _____

Checklist of Your Concerns:

Please indicate all items that apply below, and feel free to add any other concerns or issues. You may also add a note or details in the space next to the checked concerns.

___ Abuse

___ Aggression, violence

___ Alcohol use

___ Anger

___ Anxiety, worry

___ Attention, concentration, distractibility

- ___ Body Image
- ___ Career concerns
- ___ Childhood issues
- ___ Confusion
- ___ Compulsions
- ___ Custody of children
- ___ Decision making
- ___ Delusions (false ideas)
- ___ Dependence
- ___ Depression, sadness, crying
- ___ Divorce, separation
- ___ Drug use
- ___ Eating problems, overeating, undereating, vomiting
- ___ Emptiness
- ___ Failure
- ___ Fatigue, tiredness, low energy
- ___ Fears, phobias
- ___ Financial problems
- ___ Friendships
- ___ Gambling
- ___ Grief, mourning, death, loss
- ___ Guilt
- ___ Hallucinations
- ___ Headaches
- ___ Health, illness, medical concerns
- ___ Interpersonal conflicts
- ___ Impulsivness, loss of control
- ___ Irritability
- ___ Legal matters
- ___ Loneliness
- ___ Marital problems
- ___ Memory problems
- ___ Menstrual problems
- ___ Mood swings
- ___ Nervousness, tension
- ___ Obsessional, repetitive thoughts
- ___ Panic attacks
- ___ Parenting
- ___ Pregnancy
- ___ Rapid speech
- ___ Relationship problems
- ___ School problems
- ___ Self-esteem
- ___ Sexual issues
- ___ Shyness
- ___ Sleep problems
- ___ Smoking/tobacco use
- ___ Stress
- ___ Suicidal thoughts
- ___ Temper difficulties
- ___ Threats, violence
- ___ Weight and diet issues
- ___ Withdrawal
- ___ Work problems

Any other issues/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: _____