COMPREHENSIVE COUNSELING SERVICES

1115 First Street, S.W. *Phone (540)343-0004*
Roanoke, VA 24016 *Fax (540) 343-1576*

CLIENT QUESTIONNAIRE
(ADULT)

NAME: ______________________________ DATE: __________________________
DATE OF BIRTH: _____________________ HOME PHONE: ___________________
EMPLOYER: _________________________ WORK PHONE: ___________________

May we contact you at home? Yes No

May we contact you at work? Yes No

What concern(s) bring you to counseling? ______________________________________
____
____

When did you first notice this problem? ____
____
____

What changes do you want to see as a result of counseling? _______________________
____
____

PREVIOUS COUNSELING, PSYCHIATRIC HOSPITALIZATION OR CHEMICAL DEPENDENCY SERVICES: None

Place	Date	Length	Reasons	Was It Helpful?

TREATMENT RECEIVED THROUGH OTHER PROGRAMS/THERAPIES:

	PAST	CURRENT
None		
Department of Rehabilitative Services		
Day Treatment		
Special Education Type: ______________________		
Community Services Board (Mental Health)		
Mental Rehabilitation Clinics		
Substance Abuse Clinics		
Other, specify: __________________________________		

FAMILY PSYCHIATRIC HISTORY: _______________________________________

____

____

____

HOUSEHOLD MEMBERS:

Name	Age	Relationship	Willing to participate in counseling?

MEDICAL HISTORY (Include major illnesses, accidents, chronic conditions):

____

____

____

CURRENT MEDICAL PROBLEMS: ____

____

____

Revised: 5/20/2010

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? YES NO
PRIMARY CARE PHYSICIAN: ___________________________________
TELEPHONE NUMBER: _________________________
MAY WE CONTACT YOUR PRIMARY CARE PHYSICAIN TO COORDINATE YOUR CARE? YES NO

DO YOU SEE A PSYCHIATRIST? YES NO

IF YES, NAME**:** ______________________________

PHONE NUMBER: _____________________

MAY WE CONTACT YOUR PSYCHIATRIST? YES NO

MEDICATIONS TAKEN IN THE PAST?

Medication	Dosage	Prescribing M.D.	Start Date	Comments

CURRENT MEDICATIONS:

Medication	Dosage	Prescribing M.D.	Start Date	Comments

HOW WELL DO YOU COMPLY WITH TAKING YOUR MEDICTION?
GOOD MODERATE POOR

Side Effects to Current Treatment: ____
____
____

KNOWN ALLERGIES: ____
____

SUBSTANCE USE:

Substance Used	Date Last Used	Amount/frequency	# years used	Withdrawal symptoms
Nicotine				
Caffeine				
Amphetamines				
Marijuana				
Cocaine/Crack				
Hallucinogens				
Opiates				
Inhalants				
Prescription				
Over the counter				
Other				

Do you feel you have a current substance abuse problem? YES NO

Past Problem? YES NO

Do you have a history of Delirium Tremors? YES NO

History of Seizures? YES NO

FAMILY HISTORY OF SUBSTANCE ABUSE: YES NO *(If yes, indicate who and severity):

Relationship	Age	Substance	Current Use	Comments

ANY OTHER INFORMATION YOU FEEL YOUR COUNSELOR SHOULD KNOW:
____
____
____
____
____

CURRENT SYMPTOMS: (please circle)

Anhedonia
Anger
Anorexia
Anxiety
Crying
Appetite Disturbance
Weight Loss
Weight Gain
(# Of pounds_______)

Defiance
Delusions
Depression
Derealization
Depersonalization
Flashbacks
Grandiosity
Guilt
Hallucinations
Helplessness
Homicidal Ideation
Hopelessness
Hostility/Belligerence
Impaired Concentration
Inattention

Impaired functioning: School/Family
Impulsiveness
Irritability
Lability
Lack of Assertiveness
Lack of Interest
Mood Swings
Nightmares
Obsessive/Compulsive
(Specify: Thoughts/Actions):
____
Panic Attacks
Paranoia
Phobia
Social Withdrawal
Sleep Disturbance
Hypersomnia
Insomnia
Suspiciousness
Tantrums
Excessive Worry
Stealing
Fighting
Poor Social Skills
Feeling of Inadequacy

Other features (Specify): __________________________