CONFIDENTIAL QUESTIONNAIRE

Fill out the information that applies to you. Leave blank any questions you do not feel comfortable answering.

NEW CLIENT DATA

Date _____

Name _____ Age _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ Place of Birth _____

Number of Brothers _____ Number of Sisters _____ You are the _____ Child

Education _____

Religious Preference: Now: _____ In Childhood: _____

Place of Employment _____ Position _____

Single _____ Living Together _____ Engaged _____ Married _____ How Long _____ How Long Dated Mate _____

Separated _____ How Long _____ Divorced _____ How Long _____ Widowed _____ How Long _____

Number of previous marriages/significant relationships. _____ First names of previous mates, number of years with that person and number of children born to that relationship. _____

_____

Mother's Occupation _____ Her Age _____ Age at Death _____ Cause _____

_____

Father's Occupation _____ His Age _____ Age at Death _____ Cause _____

_____

How would you rate your parents' marriage? Very Happy _____ Happy _____ Average _____ Unhappy _____

If divorced, what was your age when this occurred? _____

You were referred by: _____

YOUR CHILDREN

Child's Name	Age	Sex	Comments (Custody, Support, Etc.)

YOUR PRESENT HEALTH

Excellent _____ Average _____Poor_____ When was your last medical exam? _____

Findings_____

Are you presently taking any kind of medication? Yes _____ No _____

If yes, indicate what kind _____ What purpose_____

Please give the name of your personal or family physician_____

(If more than one, please indicate_ _____

May I contact your physician(s) if appropriate to your treatment? Yes _____ No _____

Telephone _____ Address _____

List all previous psychotherapy, counseling or other treatment for personal and/or relationship problems:

Date	Types of Problem	Name of Professional or Agency

Has any of the above treatment included hospitalization? Yes _____ No _____

If so, please indicate when and for how long_____

Please indicate if there is additional medical and/or personal information not previously requested that you feel should be included. _____

_____

INFORMATION ON PARTNER

Name_____ Age_____

Address _____ City _____ Zip _____

Home Phone _____Business Phone _____

Education_____

Religious Preference: Now: _____In Childhood: _____

Place of Employment_____Position _____

Has partner ever been in therapy _____

Partner's physical health: Excellent _____ Average _____ Poor _____

Number of previous marriages: _____ First names of previous mates, number of years married to that person and number of children born to that relationship. _____

_____

PERSONAL HEALTH HISTORY

Please check which of the following you have had:

Condition	Yes	Approximate Date	Condition	Yes	Approximate Date
Accident (Serious)			**Insomnia**		
Alcoholism			**Irritableness**		
Anxiety			**Low Blood Pressure**		
Appetite Loss			**Meningitis**		
Asthma			**Menstrual Problems**		
Back Pain (Chronic)			**Miscarriage**		
Cancer			**Paralysis**		
Constipation			**Pneumonia**		
Depression			**Sexually Unresponsive**		
Diabetes			**Shaking**		
Diarrhea			**Sterility**		
Discouragement			**Surgery (Major)**		
Fainting Spells			**Tension**		
Headaches (Chronic)			**Thyroid Problems**		
Heart Problems			**Tuberculosis**		
Hemorrhoids			**Tumors**		
High Blood Pressure			**Ulcer**		
HIV			**Vasectomy**		
Hysterectomy			**Worries**		
Impotence			**Other**		

Please circle a number for each area below:

Your area of concern:	Very Dissatisfied									to Very Satisfield
Household responsibilities	1	2	3	4	5	6	7	8	9	10
Rearing of children	1	2	3	4	5	6	7	8	9	10
Sex	1	2	3	4	5	6	7	8	9	10
Social Activities	1	2	3	4	5	6	7	8	9	10
Money	1	2	3	4	5	6	7	8	9	10
Communication	1	2	3	4	5	6	7	8	9	10
Independence/Dependence	1	2	3	4	5	6	7	8	9	10
Partner	1	2	3	4	5	6	7	8	9	10
Relatives/In Laws	1	2	3	4	5	6	7	8	9	10
Religion	1	2	3	4	5	6	7	8	9	10
Alcohol	1	2	3	4	5	6	7	8	9	10
Jealousy	1	2	3	4	5	6	7	8	9	10
Infidelity	1	2	3	4	5	6	7	8	9	10
Career/Work	1	2	3	4	5	6	7	8	9	10
Physical Health	1	2	3	4	5	6	7	8	9	10

Signature _____