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Marriage Family Therapist
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CLIENT QUESTIONNAIRE

Client's Name _____ Date of Birth _____
Spouse's or Parent's Name _____ Date of Birth _____
Address _____ City _____ Zip Code _____
Phone (Home) _____ Work _____ Cell _____
Occupation _____ Social Security Number _____
Married _____ How Long _____ How Many Times _____ Single _____ Widowed _____ Divorced _____
Spouse's Work Phone _____ Health Insurance _____
Referred By _____ Church/Religious Affiliation _____

Members of Household/Family Members	D.O.B.	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

General Health _____
Name of Physician _____ Medications _____
Spouse or parent's general health _____
Are you or your spouse currently under the care of a psychiatrist, psychologist or counselor? _____
If yes, please specify name and address _____
Have you, your child or your spouse received professional counseling or psychiatrist care in the past? _____
If yes, please indicate name and address _____
Have you, your child or your spouse ever been hospitalized for an emotional or psychological reason? _____
If yes, please indicate when are where _____

(Client Questionnaire continued)

List Use of Drugs and/or Alcohol (Past and Present)

Drugs	How Often	First Date of Use	Last Date of Use
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Alcohol	How Often	First Date of Use	Last Date of Use
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Tobacco	How Often	First Date of Use	Last Date of Use
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Ever had suicidal thoughts? _____

Any suicidal attempts? _____

Were you sexually molested? _____ By whom? _____

Were you every physically abused? _____ By whom? _____

Were you ever emotionally abused? _____ By whom? _____

Client Signature _____ Date _____

Spouse's/Parent's Signature _____ Date _____

Primary Concern

Counseling Goals
