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Clinical Psychologist PSY25101

New Client Questionnaire

Personal Information:

Name: _____ Gender: _____ Date: _____

Age: _____ Ethnicity: _____ Sexual Orientation: _____

Date of Birth: _____ Place: _____

Phone(Cell/Work) _____ (Home) _____

May I contact you and leave messages at one or both of these phone numbers? _____ Yes _____ No

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

May I mail you at this address: _____ Yes _____ No; May I email you? _____ Yes _____ No

Emergency Contact _____ Phone: _____

Emergency Contact's Relationship to You: _____

Medical Doctor(s) (name/phone): _____

Occupation: _____ Employer: _____

How long have you worked there?: _____ How long in this occupation? _____

Referral Source: _____

May I inform this person that you have consulted with me? _____

Education:

What is the highest level of education you have attained? _____

Are you currently in school? _____ Yes _____ No

If you are in college, what are you studying? _____

If you have not yet completed high school, what grade are you in now? _____

Reason for Seeking Therapy (be as specific as you can: when did it start, how does it affect you in...):

Have you been in therapy before? If so, when and on what issues did you focus? Whom did you see?

What are your main worries and fears?

What do you identify as your strengths?

What do you identify as your weaknesses?

Please check if there has been any recent changes in the following:

- | | |
|--|---|
| <input type="checkbox"/> Sleep patterns | <input type="checkbox"/> Weight |
| <input type="checkbox"/> Physical activity level | <input type="checkbox"/> Focus |
| <input type="checkbox"/> Eating patterns | <input type="checkbox"/> Energy level |
| <input type="checkbox"/> General disposition | <input type="checkbox"/> Nervousness/Tension |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Other (specify)_____ |

Describe changes in areas in which you checked above:

What would you like to focus on in therapy?

Assuming that you achieved your goals for coming to therapy, what would some of your gains look like?

Relationship Information:

Current Marital Status:_____ Do you live with someone:_____

Name:_____ #Years:_____

Past & Present Marriage(s) (years together, names and statement about the nature of the relationship(s) i.e., friendly, distant, physically/emotionally abusive, loving, etc.) _____

Present Spouse/Partner: Education: _____ Occupation: _____

Children/Step/Grand: (name/ages and brief statement on your relationship with the person)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Parent/Step Parent: (name/age or year of death/cause of death, occupation, personality, how did they treat you, brief statement about the relationship):

Father: _____

Mother: _____

Step Parents: _____

If Parents Divorced: Your age at the time: _____

Describe how it affected you at the time: _____

Siblings: (name/age, if dead: age and cause of death and brief statement about the relationship):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Describe your childhood in general (relationships parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

Family Medical and Psychiatric History:

Describe any physical or mental illnesses that run in the family including depression or suicide:

Describe any abuse of substances that runs in the family:

Describe any history of violence or emotional/physical abuse:

Past/Present Psychotherapy: Please specify the month year(s) (beginning-end), estimated number of sessions, name and degree of therapist, initial reason for therapy, individual/couple/family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1.

2.

3.

Have you ever experienced the following:

	<u>Yes</u>	<u>No</u>	<u>When</u>	<u>Where</u>	<u>Your reaction to overall to experience</u>
Therapy/Counseling	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Suicidal Thoughts/Attempts	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Drug/Alcohol Treatment	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Hospitalizations	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>

If you have experienced suicidal thoughts/suicide attempt(s) or any other violent behavior, please describe (described: ages, reasons, circumstances, how etc.):

Please check behaviors and symptoms occur to you more often than you would like them to take place:

- | | | |
|--|--|--|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Recurring thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Disorganized thoughts |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Other |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Panic attacks | |

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Medical/Physical Information:

Past/Present Medical Care (major medical problems, surgeries, accidents, falls, illness-please include dates):

Are you taking any medication(s) at this time? _____

Prescription Drugs:

Type	Amount	Frequency	Date Last Used

Past/Present Drug/Alcohol Use/Abuse (AA, NA, treatments):

Coffee (# _____ cups/daily)

Cigarettes (# _____ per day)

Alcohol (# _____ drinks/daily _____ or weekly _____) Date last drank: _____

Street Drugs:

(Type): _____ Frequency: _____ Age of First Use _____ Date of Last Use _____

(Type): _____ Frequency: _____ Age of First Use _____ Date of Last Use _____

(Type): _____ Frequency: _____ Age of First Use _____ Date of Last Use _____

(Type): _____ Frequency: _____ Age of First Use _____ Date of Last Use _____

Substance of preference: _____

Describe when you typically use substances: _____

Describe any changes in your use patterns: _____

Reasons for use:

- | | |
|--------------------|-----------------|
| — Addicted | — Socialization |
| — Build confidence | — Taste |
| — Escape | — Other |
| — Self-Medication | |

Does/has someone in your family present/past have/had a problem with drugs or alcohol? ___Yes ___No

If yes, describe: _____

Have you had adverse reactions or overdosed drugs or alcohol?

(Describe): _____

Any past or current legal issues with substances? (DUI, DWI etc.) ___Yes ___No

If yes, describe: _____

List any current health concerns: _____

List any recent health or physical changes: _____

Sexual Concerns (describe any concern/problems/questions you have related to sex, for example: pain, performance issues, lack of desire/pleasure, compulsiveness/addiction, sexual trauma, relationship issues, etc.):

Please check any medical/physical health issues that apply to you:

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Sexually-transmitted diseases |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fainting | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Measles | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Cold/cough's | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nosebleeds | |

Nutrition:

Meal	How Often	Typical Foods Eaten	Typical Amount Eaten
Breakfast	___/week	_____	__low __med __high __none
Lunch	___/week	_____	__low __med __high __none
Dinner	___/week	_____	__low __med __high __none
Snacks	___/week	_____	__low __med __high __none

Comments: _____

Do you engage in eating disordered behavior? ___Yes ___No

If yes, describe: ___Restricting ___Binging ___Purging ___Extreme Diets ___Other: _____

Development:

Are there any special, unusual, or traumatic circumstances affected your development? ___Yes ___No

If yes, please describe: _____

Has there been history of child abuse? ___Yes ___No

If yes, which type(s)? ___Sexual ___Physical ___Verbal

If yes, the abuse was as a: ___Victim ___Perpetrator

Other childhood issues: ___Neglect ___Inadequate nutrition ___Other (please specify) _____

Comments: _____

How did you experience puberty (early developer, late developer etc.): _____

Social Relationships:

Check how you generally get along with other people: (check all that apply)

- Affectionate Aggressive Avoidant Fight/Argue Often
- Friendly Follower Leader Outgoing
- Shy/Withdrawn Submissive Other (specify) _____

Any concerns about social relationships? (Specify)

Culture/Ethnic:

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Yes No

If yes, describe: _____

Other Cultural/Ethnic Information: _____

Religious/Spiritual:

How important to you are spiritual matters? Not Little Moderate Much

Are you affiliated with a spiritual or religious group? Yes No

If yes, describe: _____

Were you raised within a spiritual or religious group? Yes No

If yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the therapy? Yes No

If yes, describe: _____

Are you seeking therapy for issues regarding religion/spirituality? Yes No

Military:

Military experience? Yes No

Combat experience? Yes No

Where: _____

Branch: _____

Discharge Date: _____

Date Drafted: _____

Type of Discharge: _____

Date Enlisted: _____

Rank at Discharge: _____

Leisure/Recreational:

Describe special areas of interest or hobbies (e.g. art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling etc.)

Activity	How often now?	How often in the past?

Friendships, Community, and Spirituality (describe quality, frequency, activities, etc.):

What gives you most joy or pleasure in your life?

Referral Source:

How were you referred to me? _____

If it was on the internet, what search engine and phrases did you use?

Have you visited my website? _____ Yes _____ No

If so, was it helpful? _____ Yes _____ No How so? _____

***A few times during the year I mail out a newsletter with helpful information regarding emotional wellness.

Would you like to receive this newsletter? _____ Yes _____ No

Financially Responsible Person’s Information:

Name _____ Relationship to Client _____

Phone (if different from above) _____

Address (if different from above) _____

Do you qualify for Medicare? _____ Yes _____ No