LIGHTHOUSE COUNSELING SERVICES LLC
LIGHT FOR SIGNIFICANT LIVING AND RESTORING RELATIONSHIPS

Client Questionnaire

Please fill in the information below and bring it with you to your first session.

Name: _____ Date: _____

Primary # _____ May we leave a message? Circle: Yes No

Email: _____ May we send a message? Circle: Yes No

Please note: Email correspondence is not considered to be a confidential medium of communication.

We are able to send appointment reminders to email addresses we have on file. Do you want us to send appointment reminders to you? Circle: Yes No

Please list the names of all persons living with you:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

In case of emergency who should be contacted? _____

Primary # _____ Secondary # _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No _____ Yes _____, previous therapist/practitioner: _____

Are you currently taking any prescription medication? No _____ Yes _____

If yes, please list:

_____

_____

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing: _____

_____

How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing: _____

_____

How many times per week do you generally exercise? _____

Please list any difficulties you experience with your appetite or eating _____

_____

Are you currently experiencing sadness, grief, or depression? No _____ Yes _____

If yes, for approximately how long? _____

Are you currently experiencing anxiety or panic attacks? No _____ Yes _____

If yes, for approximately how long? _____

Are you currently experiencing any chronic pain? No _____ Yes _____

If yes, please describe: _____

Do you drink alcohol? No _____ Yes _____

How often do you drink alcohol (circle one)? Daily Weekly Monthly Infrequently Never

Do you engage in recreational drug use? No _____ Yes _____

How often do you engage in recreational drug use (circle one)? Daily Weekly Monthly Infrequently Never

Are you currently in a romantic relationship? No _____ Yes _____ If so, how long? _____

On a scale of 1-10 (1 being poor and 10 being exceptional), how would you rate your relationship? _____

What do you consider to be some of your strengths? _____

_____

_____

What do you consider to be some of your weaknesses? _____

_____

_____

What would you like to accomplish out of your time in therapy? _____

_____

_____

Is there anything else you would like your therapist to know about you? _____

_____

_____