PREVAIL COUNSELING GROUP, PLLC

**ADULT CLIENT QUESTIONNAIRE**

*Please complete this questionnaire prior to your first appointment. Your answers will allow the therapist to have a better understanding of your problem(s). Feel free to ask questions if you need assistance.*

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street Address) (City, State, Zip Code)

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we leave a message? [ ] Yes or [ ] No

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we leave a message? [ ] Yes or [ ] No

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we leave a message? [ ] Yes or [ ] No

Who referred you to Prevail Counseling Group? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: [ ] African/American [ ] Asian [ ] Hispanic [ ] Native/American [ ] Caucasian [ ] Other

Are there ethnic/cultural/lifestyle/gender/religious considerations you would like us to be aware of during your care?

[ ] Yes or [ ] No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 1 – Relationship Status**

\_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Separated \_\_\_\_ Divorced \_\_\_\_ Widowed

\_\_\_\_ Committed Relationship with Significant Other

**\*** Do you have children? [ ] Yes or [ ] No **\*** Do your children live with you? [ ] Yes or [ ] No

Please indicate gender and ages of your children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2 – Residence**

\_\_\_\_ Reside Alone \_\_\_\_ Reside with Parents \_\_\_\_ Reside with Spouse/Significant Other

\_\_\_\_ Reside with Roommate(s) \_\_\_\_ Reside in Foster Care \_\_\_\_ Reside in Group Home

**Section 3 – Employment History**

Current Employment Status:

\_\_\_\_ Unemployed \_\_\_\_ Leave of Absence \_\_\_\_ Employed Part Time \_\_\_\_ Employed Full Time

\_\_\_\_ Student \_\_\_\_ Temporary Employment

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position / Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of Time with Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 4 - Education**

Please check the highest grade level you completed:

\_\_\_\_ GED \_\_\_\_ High School Diploma \_\_\_\_BA/BS Degree \_\_\_\_ Some College Course Work Completed

\_\_\_\_ Doctorate Degree \_\_\_\_ AA Degree or 2 Year Program Completion \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Difficulty Concentrating \_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Inability to Complete Course Work \_\_\_\_ Learning Disability – Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 5 – Concerns for Yourself**

What are the concerns that cause you to seek our services at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any of the following that apply to yourself:

\_\_\_\_ Depression \_\_\_\_ Abuse Issues \_\_\_\_Gambling \_\_\_\_Panic Attacks \_\_\_\_ Mood Swings

\_\_\_\_ Low Self Esteem \_\_\_\_ Hallucinations \_\_\_\_ Anger Mgmt \_\_\_\_ Parenting Concerns

\_\_\_\_ Suicidal Thoughts / Suicide Attempt(s) \_\_\_\_ Self Injury \_\_\_\_ Conflict in Relationships

\_\_\_\_ Difficulty Concentrating \_\_\_\_ Sexual Difficulty \_\_\_\_ Anxiety / Worry / Nervousness

\_\_\_\_ Alcohol/Substance Abuse/Dependence \_\_\_\_ Eating Problems/Disorder \_\_\_\_ Uncomfortable in Social Situation

**Section 6 – Occupation / Work**

\_\_\_\_ Conflict with Co-Worker (s) \_\_\_\_ Conflict with Employer / Supervisor \_\_\_\_ Poor Work Performance

\_\_\_\_ Poor Work Performance \_\_\_\_ Absent / Late \_\_\_\_ Inadequate Training / Skills \_\_\_\_ Other

**Section 7 – Relationships / Communication**

\_\_\_\_ Parent / Child Conflict \_\_\_\_ Partner / Spouse Conflict \_\_\_\_Conflict with Friends \_\_\_\_ Social Isolation

\_\_\_\_ Inadequate Social Support \_\_\_\_ Lack of Assertiveness \_\_\_\_ Fear of Social Situations \_\_\_\_ Other

**Section 8 - Legal**

\_\_\_\_ Arrested in the Past \_\_\_\_Incarcerated in Jail / Workhouse / Etc

\_\_\_\_ Legal Charges / Court Appearance Scheduled \_\_\_\_ Currently on Probation For: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 9 – Physical Health Self Care**

\_\_\_\_ Excessive Fatigue / Energy \_\_\_\_ Too Much / Too Little Sleep \_\_\_\_ Poor Hygiene

\_\_\_\_ Loss of Appetite / Anorexia / Binge Eating \_\_\_\_ Housing Problems \_\_\_\_ Little or No Exercise

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 10 – Chemical Health**

Please answer the following questions honestly.

|  |  |  |  |
| --- | --- | --- | --- |
| **Question** | **Yes** | **No** | Explain |
| Do you smoke? |  |  | **If yes, how much?** |
| Do you drink alcohol? |  |  | **If yes, how much?** |
| Number of drinks per time? **\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  | **Last use?** |
| Have you felt you ought to cut down on your drinking or drug use? |  |  |  |
| Have you felt bad or guilty about your drinking or drug use? |  |  |  |
| **Have you ever had a drink or use drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?** |  |  |  |

Please indicate the date of **LAST USE** of the following chemicals.

|  |  |
| --- | --- |
| **Chemical Type** | Date Last Used |
| Cocaine |  |
| Marijuana |  |
| Sleeping Pills |  |
| Heroin |  |
| Stimulants/Pep Pills/ Diet Pills |  |
| Tranquilizers/Acid/Angel Dust/LSD |  |
| Pain Pills/Amphetamines/Methamphetamines |  |
| **Other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

Number of times you have participated in Chemical Dependency Treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and date of last treatment program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 11 – Medical Information**

Name of primary care physician or medical group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate date you last saw your / a physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all the prescription medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list other over the counter medications you regularly take (aspirin, laxatives, vitamins, supplements and herbal remedies): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check if you have been treated for any of the following:

\_\_\_\_ High Blood Pressure \_\_\_\_ Tuberculosis \_\_\_\_ Diabetes \_\_\_\_Stroke \_\_\_\_Thyroid Problem

\_\_\_\_ Meningitis \_\_\_\_ Heart Problem \_\_\_\_ Ulcers \_\_\_\_ Hepatitis \_\_\_\_ Seizures

\_\_\_\_ Cancer \_\_\_\_ Organic Brain Dysfunction

Please list any other medical conditions we should be aware of (surgeries, auto accident injuries, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 12 – Current / Previous Mental Health Services**

Name of current Psychiatrist / Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years Treated: \_\_\_\_\_\_\_\_

* Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date and place of any of most recent psychiatric hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years Treated: \_\_\_\_\_\_\_\_

* Issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If members of your family have been treated for a mental illness, please indicate relationship to you and diagnosis: \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other background information you feel may be helpful to the therapist in understanding you: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_