

Client Name _____ Date _____

Client Questionnaire

Please rate the following life areas which currently cause issues of concern/problems for you on a 1 to 5 scale where **1 = no concern** and **5 = primary, strong concern**. N/A denotes “not applicable.” Please circle the appropriate responses.

Marital or partner relations?	1	2	3	4	5	N/A
Issues related to sex/sexual relationships?	1	2	3	4	5	N/A
Family relations with your parents and/or siblings?	1	2	3	4	5	N/A
Special family issues (step and blended families, adoption)?	1	2	3	4	5	N/A
Other interpersonal relationships (friend, peer)?	1	2	3	4	5	N/A
General mental and emotional health (e.g. anxiety, depression)?	1	2	3	4	5	N/A
Alcohol and/or substance abuse and/or dependence? <input type="checkbox"/> Self <input type="checkbox"/> Family Member	1	2	3	4	5	N/A
Job/Career and/or related job/career issues?	1	2	3	4	5	N/A
School and/or related school issues?	1	2	3	4	5	N/A
Financial and/or legal situation?	1	2	3	4	5	N/A
Concern for physical state of health?	1	2	3	4	5	N/A
Physical, verbal, emotional and/or sexual abuse?	1	2	3	4	5	N/A
General lifestyle (lifestage) changes?	1	2	3	4	5	N/A
Other:	1	2	3	4	5	N/A

Please check those items which describe your experience or behavior within the past month:

<input type="checkbox"/> Tremors, tics, shaking	<input type="checkbox"/> Increased sweating	<input type="checkbox"/> Feeling restless
<input type="checkbox"/> Headaches	<input type="checkbox"/> Hives	<input type="checkbox"/> Feeling afraid
<input type="checkbox"/> Muscle pains	<input type="checkbox"/> Confusion	<input type="checkbox"/> Feeling irritable
<input type="checkbox"/> Nausea / upset stomach	<input type="checkbox"/> Inability to concentrate	<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Feeling of anger / rage	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Feeling of sadness	<input type="checkbox"/> Increase of appetite /
<input type="checkbox"/> Constipation	<input type="checkbox"/> Desire to cry	eating
<input type="checkbox"/> Tension in chest	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Dizziness / fainting	<input type="checkbox"/> Increased sleeping	<input type="checkbox"/> Increased smoking
<input type="checkbox"/> Fatigue / weakness	<input type="checkbox"/> Drug or Alcohol use	Other _____