

## Client Information Questionnaire

Your cooperation in completing this questionnaire will be helpful in the planning services and maintaining communication throughout the therapy process. Please answer each item carefully. Feel free to ask for any clarification needed. When finished you can use the information at the bottom to either scan and email or fax this document back to us.

Full Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ e-mail: \_\_\_\_\_

Telephone number(s): Home ( \_\_\_\_ ) \_\_\_\_\_ Work ( \_\_\_\_ ) \_\_\_\_\_ Mobile ( \_\_\_\_ ) \_\_\_\_\_

Age \_\_\_\_ Male Female May your therapist leave messages or voice mail for you? Y / N \_\_\_\_\_

Marital Status (check one): \_\_\_\_\_  
Single Married Separated Divorced Remarried Widowed Other

Occupation: His \_\_\_\_\_ Hers \_\_\_\_\_

Gross annual income: His \_\_\_\_\_ Hers \_\_\_\_\_

Check highest level of education:

Grade school Middle school High School Some college  
Bachelor's degree Master's degree Advanced degree (Ph.D., M.D., etc.)

Religious preference : His \_\_\_\_\_ Hers \_\_\_\_\_

Where do you attend? \_\_\_\_\_

Briefly describe your reason(s) for seeking help: \_\_\_\_\_

Who suggested you contact me?

Friend \_\_\_\_\_ Physician (name) \_\_\_\_\_ Other \_\_\_\_\_

Website: \_\_\_\_\_ Minister (name) \_\_\_\_\_

Are you currently in therapy elsewhere? YES NO

If so, with whom? \_\_\_\_\_

Have you ever consulted a professional counselor? YES NO

If yes, Name \_\_\_\_\_ When? \_\_\_\_\_

Address \_\_\_\_\_

Who is your physician? \_\_\_\_\_

Are you presently taking any medication? YES NO

If yes, please list \_\_\_\_\_

Do I have permission to contact your physician in order to coordinate services? YES NO

List any health problems for which you currently receive treatment: \_\_\_\_\_

Have you ever considered suicide? YES NO

Have you ever attempted suicide? YES NO If so, when? \_\_\_\_\_

Initials: \_\_\_\_\_

Circle any of the following which are presently causing you difficulty:

|               |                   |                |                  |              |                 |
|---------------|-------------------|----------------|------------------|--------------|-----------------|
| Assertiveness | Health problems   | Career choices | Stomach problems | Parenting    | Alcohol use     |
| Legal matters | Self-concept      | Bowels         | Sexual Problems  | Marriage     | Religion        |
| Nightmares    | Loneliness        | Concentration  | Separation       | Bed-wetting  | Ulcers          |
| My thoughts   | Suicidal thoughts | Nervousness    | Energy           | Sleep        | Decision making |
| Children      | Parents           | Insomnia       | Education        | Divorce      | Relaxation      |
| Ambition      | Asthma            | Temper         | Depression       | Shyness      | Stress          |
| Inferiority   | Friends           | Dating         | Memory           | Drug use     | Headaches       |
| Tiredness     | Finances          | Appetite       | School           | Unhappiness  | Fears           |
| Work          | Confusion         | Premarital     | Food             | Self-control | Sadness         |
| In-laws       | My past           | Guilt          | Allergies        | Abuse        |                 |

Now, put a star \* beside the **TWO** circled items that are causing you the **MOST** difficulty.

If never married, check box and skip this section:  Never married

Please give your marital history:

1<sup>st</sup> marriage: Date began \_\_\_\_\_ Ended? \_\_\_\_\_ Name of spouse \_\_\_\_\_

Children and ages \_\_\_\_\_

2<sup>nd</sup> marriage: Date began \_\_\_\_\_ Ended? \_\_\_\_\_ Name of spouse \_\_\_\_\_

Children and ages \_\_\_\_\_

3<sup>rd</sup> marriage: Date began \_\_\_\_\_ Ended? \_\_\_\_\_ Name of spouse \_\_\_\_\_

Children and ages \_\_\_\_\_

4<sup>th</sup> marriage: Date began \_\_\_\_\_ Ended? \_\_\_\_\_ Name of spouse \_\_\_\_\_

Children and ages \_\_\_\_\_

List the members of your family and all others living in your home:

| <u>Name(s)</u> | <u>Age/Birth Date</u> | <u>Relationship</u> | <u>Occupation</u> |
|----------------|-----------------------|---------------------|-------------------|
|----------------|-----------------------|---------------------|-------------------|

|       |       |       |       |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
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| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Please provide an additional information which you feel may be useful to your therapy \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

By signing, I acknowledge my receipt of disclosure statement and indicate that I have reviewed the information provided concerning confidentiality and legal exceptions to confidentiality, fees, responsibilities for payment, and credentials of my therapist, Jayson Graves, Healing for the Soul/The SoulHealer Foundation.

\_\_\_\_\_  
Client/s Signature/s

Thank you...please either **scan & email** to [help@healingforthesoul.org](mailto:help@healingforthesoul.org) or **fax** to 719-325-7057