Today's Date: _____

Trestlewood Counseling Group
5104 Lovers Lane
Portage, MI 49002
269.743.7360

Confidential Client Questionnaire

Name: _____ Phone: HM: _____Is it okay to leave a message? Yes / No

Birth Date: _____ Age: _____Cell: _____Is it okay to leave a message? Yes / No

Address: _____

Sexual/Gender Identity: _____ Marital/Relationship Status: _____

Religious/Spiritual Orientation: _____ Military/Veteran? □ Yes □ No

Responsible Party: □ Self □ Parent _____ □ Guardian_____ □ Ward of the State

Occupation/Employer_____

Referral Source:_____ Reason for referral_____

In Case of Emergency:

Emergency Contact: _____ Relationship:_____ Phone:_____

Insurance Information

Insurance: _____ Name of Policy Holder:

_____

Policy ID: _____ DOB of Policy Holder: _____

Employer of Policy Holder (if different): _____

Policy Holder Address (if different): _____

Medical & Health Information

Primary Physician: _____ Date of last physical exam: _____

Name of Medical Clinic & Address: _____

Medical Clinic Phone Number: _____ Medical Clinic Fax: _____

Current Medical Conditions: _____

Please list all medications you are presently taking:

Name:	Dosage:	Frequency:

Average number of hours of sleep per night_____ Average amount of caffeine consumed per day: _____(cups)

Recent Stressors *(over the past year):*

____ separation or divorce
____ loss of income
____ serious illness or injury
____ victim of crime
____ death of family member
____ child moved out
____ serious illness of family member
____ history of abuse/neglect
____ Immigration/Refugee Status
____ legal problems
____ death of close friend
____ loss of job
____ Change of residence/housing concerns
____ birth of child
____ marriage
____ current abuse/neglect
____ discrimination(race/gender/sex/religious/etc.)
____ other _____

Substance Use:

Do you currently use any of the following?

Do you drink alcohol? □ Yes □ No — How many alcoholic beverages do you drink? _____

Do you use tobacco? □ Yes □ No — Cigarettes: Amount per day _____

Marijuana □ Yes □ No — Pills (Not as directed/ prescribed by your physician) □ Yes □ No

Cocaine/Crack □ Yes □ No — Methamphetamine/Amphetamine □ Yes □ No

Heroin □ Yes □ No — Other _____

Legal Information

If you are currently involved in any legal action in court, please indicate the nature of the proceeding (including family court).

_____

_____

Are you on probation? □ Yes □ No

If yes, please provide the name of your Probation Officer: _____

History

Do you experience thoughts of suicide? □ Yes □ No □ In past

Have you attempted suicide? □ Yes □ No If yes, when was your last suicide attempt? _____

Have you been the victim of sexual assault or rape? □ Yes □ No

Have you been physically assaulted/threatened by another person? □ Yes □ No

Have you been a victim of mental/emotional abuse? □ Yes □ No

Treatment History

Have you had past counseling or therapy experiences? □ Yes □ No If yes, where? _____

Have you been hospitalized for mental health reasons before? □ Yes □ No Last admission: _____

Have you had past outpatient substance abuse treatment? □ Yes □ No If yes, where _____

Have you participated in inpatient substance abuse treatment before? □ Yes □ No Last admission: _____

Are you currently seeing a psychiatrist? □ Yes □ No Who/Where _____

Was past treatment history helpful or not? Explain: _____

_____

Family History

Do any of your close relatives have a history of mental health concerns? □ Yes □ No

If yes, please describe: _____

Did they seek treatment for identified mental health concerns? □ Yes □ No

Check any of the following that applied to your family life as you were growing up:

____ Alcohol or substance-abusing parent ____ Suicide attempt by parent/family member

____ Incest in the family ____ Domestic violence, spouse abuse

____ Physical/sexual abuse of children ____ Immigration

Explain: _____

Physical Symptoms

- ☐ Heart Racing
- ☐ Decreased Energy
- ☐ -Hyperactivity
- ☐ -Lots of aches and pains
- ☐ -Difficulty managing pain
- ☐ -sleeps too little
- ☐ -Sleeps too much
- ☐ Nightmares
- ☐ -excessive energy
- ☐ -panic attacks
- ☐ -Physical disability
- ☐ -picky eater
- ☐ -Sensitive to noise, sound, texture, or light
- ☐ Stomachaches/digestive issues
- ☐ Restrictive Eating
- ☐ Binging/Purging
- ☐ Overeating
- ☐ Poor Hygiene
- ☐ Sexual Concerns

Behavioral Symptoms

- ☐ Excessive Crying
- ☐ Impulsivity
- ☐ Can't have fun
- ☐ Can't sit still
- ☐ Problems following rules
- ☐ Poor social skills
- ☐ Lack of focus
- ☐ Makes Careless Errors or overlooks details
- ☐ Difficulty making decisions
- ☐ Skin picking, hair pulling, nail biting
- ☐ Problems at work or school
- ☐ Avoids going places
- ☐ Self-harm
- ☐ Isolating self from others
- ☐ Checking things repeatedly
- ☐ Difficulty finishing projects or tasks
- ☐ Aggression
- ☐ Talking excessively
- ☐ Excessive use of drugs, alcohol or medication
- ☐ Lying or stealing
- ☐ Threatening or bullying
- ☐ Hoarding Food or things
- ☐ Legal problems
- ☐ Difficulty waiting his or her turn
- ☐ Difficulty handling change
- ☐ Risk taking behavior

Emotional Symptoms

- ☐ Easily angered
- ☐ Irritable
- ☐ Guilt/shame
- ☐ Separation Anxiety from caregivers
- ☐ Can't control temper
- ☐ Abrupt mood changes
- ☐ Feeling Stuck
- ☐ Overwhelmed
- ☐ Apathetic
- ☐ Unmotivated
- ☐ Loss of interest in things I enjoy

Thoughts symptoms

- ☐ Lack of confidence
- ☐ Suspicious
- ☐ Paranoid
- ☐ Poor self-worth
- ☐ Perfectionism
- ☐ Poor body image
- ☐ "No one understands me"
- ☐ Thoughts of harming self
- ☐ Suicidal Ideation
- ☐ Excessive worries or fears
- ☐ Afraid of being judged or rejected
- ☐ Thoughts of harming others

Completed by: _____ Date: _____