**Lawrence E. Hedges, Ph.D. Psy.D., ABPP**
**1439 E. Chapman Avenue**
**Orange, CA 92866**
**Phone/Fax (714) 633-3933**
www.ListeningPerspectives.com

# Psychotherapy Client Questionnaire

Name:_____ Date:_____

**REFERRED BY:**

Name:_____Phone #:_____

Address:_____

May I inform this person that you have consulted with me?_____

_____
Your Signature

**CONFIDENTIALITY STATEMENT:**

Case records are strictly confidential. No outsider, not even your closest relative or family doctor is permitted to see your case record without your written permission or a court order.

**1. GENERAL**

**A.** Name:_____

Address:_____

Home Phone:_____Work Phone:_____

Fax:_____E-Mail:_____

Age:_____Date of Birth:_____Place of Birth:_____

**B. What is your present living situation?**_____

_____

**C. Name and ages of children**

Name:_____Age:_____

Name:_____Age:_____

Name:_____Age:_____

Name:_____Age:_____

Name:_____Age:_____

**D. Give a short history of your closest interpersonal relationships:**

_____

_____

_____

_____

_____

_____

_____

_____

Education:_____

Occupation:_____

Currently Working:_____

What is your present job situation?_____

_____

**2. PROBLEM AREA**

**A. State in your own words the nature and history of your chief complaint:**

_____

_____

_____

**B. Present interests, hobbies, activities:**_____

_____

_____

_____

**C. How is most of your free time occupied? _____**

_____

_____

_____

_____

**D. What are your life goals?_____**

_____

_____

_____

_____

**E. What are your five greatest fears?**

**1. _____**

**2. _____**

**3. _____**

**4. _____**

**5. _____**

**3. FAMILY HISTORY**

**A.** Father's name:_____

Age:_____ Health:_____

If deceased, age and cause of death:_____

Your age at time of death:_____

**Give a description of your father's personality:**

**B.** Mother's name:_____

Age:_____ Health:_____

If deceased, age and cause of death:_____

Your age at time of death:_____

**Give a description of your mother's personality:**

_____

**C. Brothers/Sisters (Names, sex, age, and something about each):**
[Are there significant others from your growing up years?]

_____

_____

_____

_____

_____

_____

_____

**D. Who are the most important people in your life? Describe.**

_____

_____

_____

_____

**Previous Medical, Psychiatric and Psychotherapy Contacts**

**E. Have you ever been in psychotherapy before?**_____

If yes, when?_____

May I contact your previous therapist(s)?_____

Therapist:_____

Address:_____

Phone #_____

Therapist:_____

Address:_____

Phone #_____

**F. Have you ever been hospitalized for an emotional problem?**

If yes, when, where, and how long?_____

_____

If yes, when, where, and how long?_____

_____

**G. Have you ever made a suicide attempt? If yes, describe it, when, and the circumstances leading up to the attempt.**

_____

_____

_____

_____

_____

**H. Have any close relatives been treated for psychiatric problems?**

If yes, please specify:_____

_____

**I. Has any relative of yours committed suicide?**

If yes, please specify:_____

_____

**J. Give details of all forms of abuse you were subject to in childhood (neglect, verbal violence, sexual).**

_____

_____

_____

_____

**K. Give a brief history of any litigation you have been involved in regarding child custody, divorce, liability, or medical malpractice.**

## 5. SELF DESCRIPTION

Give a word-picture of yourself, i.e., describe yourself in terms of how you presently feel and see yourself (include both negatives and positives):

## 6. MEDICAL HISTORY

**A. Past Medical History Have you had any of these childhood illnesses?**

| | NO | YES | DON'T KNOW |
|---|---|---|---|
| Measles | ____ | ____ | _____ |
| Mumps | ____ | ____ | _____ |
| Whooping Cough | ____ | ____ | _____ |
| Chicken Pox | ____ | ____ | _____ |
| Rheumatic Fever | ____ | ____ | _____ |
| Rubella (German Measles) | ____ | ____ | _____ |

**Please list medical hospitalizations and operations. Give diagnoses and dates:**

_____

_____

_____

**B. Have you ever suffered from any of the following illnesses?**

| | NO | YES | DATE OF ONSET |
|---|---|---|---|
| Cancer | ____ | ____ | _____ |
| T.B. | ____ | ____ | _____ |
| Diabetes | ____ | ____ | _____ |
| Thyroid Trouble | ____ | ____ | _____ |
| Kidney Trouble | ____ | ____ | _____ |
| High Blood Pressure | ____ | ____ | _____ |
| Eye Trouble | ____ | ____ | _____ |
| Heart Trouble | ____ | ____ | _____ |
| Neurological Disease | ____ | ____ | _____ |
| Ulcers | ____ | ____ | _____ |
| Head Injury | ____ | ____ | _____ |
| D.T.'s | ____ | ____ | _____ |
| Allergies | ____ | ____ | _____ |

List all Allergies:_____

_____

Any other serious illnesses?_____

**C. Family History**

Have any of your blood relatives suffered from any of the illnesses listed above? If yes,

please specify ailment and relative:

_____

_____

_____

Any other serious illness?_____

**D. Drug/Medication History**

Because many drugs (legal and illegal) have psychological effects, it is important for me to know what drugs you are currently taking and/or have taken in the past. This information will remain strictly confidential, but it is very important for me to know before you begin therapy so that an accurate assessment of your problem and situation can be made. Please list all legally prescribed and illegal drugs ever used (past or present) and describe how often you use them and what effects you seek:

_____

_____

_____

_____

_____

**Have any of these drugs been prescribed by a physician?**

Yes____ No____ If so, which drugs and for what reason?

_____

**E. Nutrition**

Is your diet unusual in any way? Yes____ No____

If so, how?_____

_____

**F. Symptoms**

Check any of the following symptoms which apply to you at this time. Also indicate when any of these symptoms have applied to you in the past.

| | | | |
|---|---|---|---|
| Falling Hair | _____ | Fainting Spells | _____ |
| Weight Gain | _____ | Difficulty Sleeping | _____ |
| Fatigue | _____ | Drinking too much Fluid | _____ |
| Constipation | _____ | Blurred Vision | _____ |
| Dry Skin | _____ | Deafness | _____ |
| Weakness | _____ | Ringing in Ears | _____ |
| Weight Loss | _____ | Chest Pain | _____ |
| Tremor | _____ | Shortness of Breath | _____ |
| Big Appetite | _____ | Tingling of Hands or Feet | _____ |
| Fast Heart Beat | _____ | Ankle Swelling | _____ |
| Diarrhea | _____ | Indigestion | _____ |
| Poor Appetite | _____ | Nausea or Vomiting | _____ |
| Headaches | _____ | Urinary Difficulties | _____ |
| Headaches | _____ | Problems with Sexual | |
| Dizziness | _____ | Organs | _____ |

**G. Menstrual History, Issues, or Problems:**_____

_____

_____

_____

_____

**H. Smoking and Drinking**

Do you smoke (anything)?_____ What?_____

How much?_____ Frequency?_____

Do you drink alcohol? _____ If yes, how much?_____

What happens to you when you smoke or drink, that is, what does it do for you?

_____

_____

**Describe any physical symptoms at all that you have when you smoke or drink.**

_____

_____

**I. What kind, and how much physical exercise do you get?**

_____

_____

_____

**J. Describe the spiritual/religious aspects of your life:**

_____

_____

_____

_____

**K. Have you ever been hypnotized? If so, for what and what were the results?**

_____

_____

_____

_____

**L. Have you ever been on Worker's Comp or Disability. For what, how long, results?**

_____

_____

_____

_____

**M. In case of emergency, please notify one of the following three people: May I have your permission to inform one or all of these people if you are ever in danger?**

Yes _____ No _____

1._____

| Name | Daytime Phone | Evening Phone | Address |
|---|---|---|---|

2._____

| Name | Daytime Phone | Evening Phone | Address |
|---|---|---|---|

3._____

| Name | Daytime Phone | Evening Phone | Address |
|---|---|---|---|

This questionnaire supplements previous informed consents.

_____ _____

Your Signature Date

_____ _____

Therapist's Signature Date

**For the Therapist Use Only!**

**Diagnostic Impressions:** _____

Date

_____

_____

_____

**Treatment Plan:** _____

Date

_____

_____

_____

_____

**Referrals:**

_____Date_____

_____Date_____