

**Cicelia Como, M.A., LPC-Intern**  
**Supervised by Debbie Edmunds, MA, LPC-S**

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**New Client Questionnaire/ Psychosocial History**  
(To be completed by the client)

Please complete this form to the extent that you feel comfortable. If any questions are particularly difficult, painful, or not applicable, please feel free to leave them blank and/or discuss them with me during your session. If you need more space for any answers, please use margins or back of sheet.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Gender: \_\_\_F \_\_\_M Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Referred By: \_\_\_\_\_  
(e.g., Name of physician, website, friend, yellow pages, etc.)

Primary reason(s) for seeking services: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family Information

Relationship	Name	Age	Living?		Lives with you?	
			Yes	No	Yes	No

Mother \_\_\_\_\_

Father \_\_\_\_\_

Spouse/Partner \_\_\_\_\_

Children \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Significant others (e.g., siblings, grandparents, etc.) Please specify relationship.

Relationship	Name	Age	Living?		Lives with you?	
			Yes	No	Yes	No

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

**Current Marital Status: (please circle all that apply)**

Single	Married	Living together	Committed relationship
Divorced	Widowed	Engaged	Separated

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Length of current marriage/relationship: \_\_\_\_\_

Number of marriages/serious relationships: \_\_\_\_\_

Assessment of current relationship (if applicable):

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I feel safe in my current living situation:  Yes  No (please explain)

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I feel safe in my current romantic relationship:  Yes  No (please explain)

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Growing up, I was raised by/lived with:

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My childhood was:

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I usually get along with my parents:  Yes  No because:

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I usually get along with my siblings:  Yes  No because:

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**Development**

Are there any special, unusual, or traumatic circumstances that affected your development?

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Type of discipline used in my home when growing up:

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Has there been a history of abuse in your past?  Yes  No

If yes, which type(s):

Emotional/verbal abuse  Physical  Sexual  Neglect/Abandonment

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social Relationships**

I usually get along with other adults:  Yes  No because:

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

I usually get along with children:  Yes  No because:

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

I have friends:  No  Yes # \_\_\_\_\_ Males # \_\_\_\_\_ Females

Sexual orientation: \_\_\_\_\_ Comments: \_\_\_\_\_

Sexual problems or dysfunction:  Yes  No

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

**Cultural/Ethnic**

With which cultural, racial, or ethnic groups do you identify? \_\_\_\_\_

Are you experiencing any concerns related to cultural, racial, or ethnic issues?  No  Yes If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Other pertinent cultural/racial/ethnic information:

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

Religious/Spiritual Affiliation:

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

Would you like your spiritual/religious beliefs incorporated into therapy?  Yes  No

If yes, please describe:

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

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**Legal**

**I have been involved with the legal system: No Yes Describe:**

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**Education/Employment**

**Highest level of education completed (including school name and diploma/degree):**

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**Currently enrolled as a student? No Yes**

**Current employer: N/A** \_\_\_\_\_

**Job title/Occupation: N/A** \_\_\_\_\_

**Career Concerns?** \_\_\_\_\_

**Military experience (i.e., branch, rank, type of discharge, combat experience, etc.): N/A**

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**Medical/Physical Health**

**I have the following medical problems:**

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**List all current medical issues and past accidents/surgeries/medical issues that may still affect you presently.**

**I take the following prescription or over the counter medications including vitamins/supplements/herbs:**

Name of medicine	Reason

**Use additional space at bottom/back of this page if needed.**

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please describe any recent changes in sleep, eating, behavior, weight, disposition, or energy level:**

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**List any concerns you may have about your sleep and/or eating habits:**

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**Chemical Use History**

**I have used the following types of alcohol/illegal substances: put a \* by your drug of choice**

Name of drug	Age of first use	Amount/Frequency	Date of last use

**Are you or someone you love concerned about your use of alcohol or drugs?**

Yes     No

**Have you ever sought help (inpatient treatment or 12 step program) for substance abuse or addiction?**

Yes    No                      **If yes, please describe:** \_\_\_\_\_

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**Please list any family history of drug or alcohol abuse:**

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**Counseling/Prior Treatment History**

**I have cut, burned, scratched, or hurt myself before:  No  Yes If yes, please explain:** \_\_\_\_\_

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**I have attempted suicide before:  No  Yes If yes, please explain:** \_\_\_\_\_

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**Are you currently suicidal?  No                                       Yes**

**If yes, please explain:**

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I have thought about killing someone else:  No  Yes because: \_\_\_\_\_

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I have had previous treatment (e.g., inpatient, private therapist, residential treatment):

No  Yes because: \_\_\_\_\_

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If you have previously seen a therapist, what did you like or dislike about that experience \_\_\_\_\_

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I am willing to receive therapy:  No because: \_\_\_\_\_  Yes because: \_\_\_\_\_

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What are your expectations or goals for therapy? \_\_\_\_\_

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Please list any other information that might be helpful in understanding you or assist in your therapy: \_\_\_\_\_

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Client or Legal Guardian Name: \_\_\_\_\_

Client or Legal Guardian Signature: \_\_\_\_\_