

Shawnesse Herbert, 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):

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

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

Growing up, I was raised by/lived with:

My childhood was:

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

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

Development

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

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: _____

Legal

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

Education/Employment

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

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

Medical/Physical Health

I have the following medical problems:

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:

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

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:** _____

Please list any family history of drug or alcohol abuse:

Counseling/Prior Treatment History

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

I have attempted suicide before: No Yes If yes, please explain: _____

Are you currently suicidal? No Yes

If yes, please explain:

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Name: _____ Date: _____

I have thought about killing someone else: No Yes because: _____

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

No Yes because: _____

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

I am willing to receive therapy: No because: _____ Yes because: _____

What are your expectations or goals for therapy? _____

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

Client or Legal Guardian Name: _____

Client or Legal Guardian Signature: _____