#

## NEW CLIENT HISTORY QUESTIONNAIRE

#  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hispanic/Latino Yes No

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_\_ May we leave a message with you at this number? Yes No

Home Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_\_ May we leave a message with you at this number? Yes No

Work Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_\_ May we leave a message with you at this number? Yes No

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we email to this address? Yes No

Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Insurance Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_ SS#:\_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_\_

Insurance ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Are you right-handed or left-handed? (check one)  Right  Left  Ambidextrous

Is English your first language? (check one)  Yes  No

If not, what is your first language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  Yes  No Has anyone assisted you with this form? If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes  No Are you involved in any litigation, lawsuit, worker’s compensation, disability?

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  Yes  No Do you wear or need glasses to correct your vision?

  Yes  No Do you wear or need a hearing aid?

What is your understanding of the reason for this evaluation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

## DEVELOPMENTAL / PERSONAL

 Yes  No Did your mother have complications during pregnancy or birth?

 Yes  No Any delays in walking, talking, reading?

 Yes  No Did you have any speech difficulties?

 Yes  No Were you ever diagnosed with a learning disability or ADD/ADHD?

 Yes  No Ever referred for academic, psychological, or neuropsychological testing?

 Yes  No Were you ever referred for special education or gifted courses?

 Yes  No Did you ever repeat or fail a grade?

 Yes  No Did you have any problems with socializing?

 Yes  No Did you graduate from high school?

 Year of graduation: \_\_\_\_\_\_\_\_\_\_ GPA:

|  |  |  |  |
| --- | --- | --- | --- |
| **COLLEGES/UNIVERSITIES ATTENDED** | **Major** | **GPA** | **Degree Received** |
|  |  |  |  |
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Where were you born and raised?

Father’s profession

Mother’s profession

Siblings (how many and their ages)

What is your ethnic/cultural background?

What is your religious or spiritual orientation?

What is your current occupational status? Full-time employment Part-time employment Not working Retired

Current or most recent place of employment:

What is your relationship status? Divorced Married Separated Single Widowed

Children (how many and their ages) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes  No Have you ever been in the military?

 Yes  No Were you ever the victim of sexual, physical, verbal, or emotional abuse?

 Yes  No Have you ever witnessed any domestic violence?

 Yes  No Have you ever assaulted anyone?

 If yes, please explain.

  Yes  No Have you ever been arrested?

 If yes, please explain.

## SYMPTOMS

 **Are you currently experiencing any of the following symptoms?**

 Yes  No Forgetting conversations, movies, books (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Forgetting to attend appointments (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Forgetting to take your medication (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Getting lost in familiar places (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Forgetting childhood events after the age of 6 (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Not recognizing important people in your life (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Losing your train of thought (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Excessive daydreaming (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Easily distracted (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Beginning lots of tasks and not finishing them (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Speaking ability (word finding, naming) (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Not being able to express yourself in words (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Not able to think of the word you want (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Not understanding what people say to you (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Judging heights, depth, distance (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Difficulty with problem-solving, organizing (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Acting first, thinking later (impulsivity) (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Trouble controlling your temper (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Personality changes (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Headaches (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Blurred/double vision (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Ringing in ears (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Lightheadedness/fainting spells (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Poor balance (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Convulsions/seizures (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Tremors (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Muscle weakness or paralysis (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Fatigue (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Poor coordination/falling episodes (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Numbness/tingling (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Changes in taste or smell (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Yes  No Difficulty swallowing (if Yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

## MEDICAL

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| **Has a doctor ever told you have:** | **Yes** | **No** | **If yes, treatment** |
| Diabetes |  |  |  |
| High blood pressure |  |  |  |
| High cholesterol |  |  |  |
| Heart disease (heart attack, strokes) |  |  |  |
| Sleep apnea |  |  |  |
| Thyroid disturbance |  |  |  |
| Cirrhosis of the liver |  |  |  |
| Hepatitis |  |  | What type? |
| HIV/AIDS |  |  |  |

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| --- | --- | --- |
| **Other past or current medical problems** | **Date(s) of diagnosis/occurrence** | **Treatment** |
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 Yes  No Have you ever had a serious medical accident or injury?

 If yes, please give details.

 Yes  No Have you ever had a history of surgeries?

If yes, please give details.

 Yes  No Have you ever sustained a head injury?

 Yes  No Did you lose consciousness?

 If yes, please give details.

 Last thing you remember **before** injury.

 Last thing you remember **after** injury.

 Yes  No Have you ever had brain surgery?

 Yes  No Have you ever had a seizure?

 Yes  No Have you ever consulted with a neurologist?

 Yes  No Have you ever been diagnosed with a neurological disorder?

If yes, please give details.

 Yes  No Have you ever had neuroimaging (MRI, CT scan, PET, SPECT)?

 Yes  No Have you ever had radiation treatment or chemotherapy?

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| --- | --- | --- |
| **List current medications you take, including vitamins, hormones, and non-prescription drugs.** | **Dose** | **How Often?** |
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| **Please answer the following questions.** |  **Yes** |  **No** | **Drinks per day** | **Drinks per week** |
| Do you consume caffeine (coffee, tea, soda)? |  |  |  |  |
| Do you consume alcohol? |  |  |  |  |
| Have you ever felt the need to cut down on your drinking ? |  |  |  |
| Have you ever been charged with a DUI? |  |  | If yes, please explain (give dates). |
| Have you had any other legal problems associated with alcohol or drug use? |  |  | If yes, please explain (give dates). |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Have you ever used:** | **Yes** | **No** | **Frequency of use** | **Last use of this substance** |
| Nicotine/Tobacco products |  |  |  |  |
| Marijuana |  |  |  |  |
| Cocaine |  |  |  |  |
| Heroin |  |  |  |  |
| Methadone |  |  |  |  |
| Other? (please specify) |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Do any of your biological relatives have:** | **Yes** | **No** | **If yes, whom?** |
| Diabetes |  |  |  |
| High blood pressure |  |  |  |
| High cholesterol |  |  |  |
| Heart disease (heart attacks, strokes) |  |  |  |
| Epilepsy or seizures |  |  |  |
| Neuromuscular disease |  |  |  |
| Huntington’s or Parkinson’s disease |  |  |  |
| Dementia |  |  |  |
| Other diseases or conditions |  |  |  |
| History of alcohol abuse |  |  |  |
| History of substance abuse |  |  |  |

### MENTAL HEALTH

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| --- |
| **Have you experienced difficulties with the following?** |
| **Symptoms** | **Now** | **Past** | **Symptoms** | **Now** | **Past** |
|  Depression |  |  | Traumatic life events |  |  |
| Mood swings |  |  | Suicidal thoughts |  |  |
| Chronic worries or anxiety |  |  | Suicide attempts |  |  |
| Panic Attacks |  |  | Thoughts of harming others |  |  |
| Compulsive behaviors |  |  | Attempts to harm others |  |  |
| Obsessive thought patterns |  |  | Seeing or hearing things others don’t |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Have you ever:** | **Yes** | **No** | **Provider/Place** | **Year(s)** |
| Had counseling or psychotherapy? |  |  |  |  |
| Seen a psychiatrist? |  |  |  |  |
| Been psychiatrically hospitalized? |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Have any of your biological relatives had difficulties with** | **Yes** | **No** |  **If yes, who?** |
| Depression |  |  |  |
| Anxiety |  |  |  |
| Learning problems/Attention deficit disorder |  |  |  |
| Schizophrenia |  |  |  |
| Bipolar (manic depressive) disorder |  |  |  |
| Paranoia |  |  |  |
| Hearing voices/seeing things others didn’t |  |  |  |
| Odd beliefs |  |  |  |
| Suicide attempts |  |  |  |