Claret Center
Counseling Questionnaire

Identification Information

your name: ______________________ cell phone: ____________________ age: ____________
address: ______________________ occupation: ____________________ birthdate: ____________
city: ______________________ ______________________________ mm/day/yr
state, zip ______________________ private email: ______________________________

I give permission to communicate through my email listed above: ☐ Yes ☐ No
I give permission to communicate by text: ☐ Yes ☐ No

highest level of education completed: ____
name of college/university if attended: ____
field of study: ____

Emergency Contact

Name of contact: __________________________ Relationship: ______________________________
Phone # of contact: __________________________ Permission to contact in emergency? ☐ Yes ☐ No

Religious background

Religious affiliation: ______________________________
How important to you are spiritual matters? ___not ___little ___moderate ___much

Relationships

Significant Relationship Status (check one):

☐ single ☐ married ☐ separated ☐ Committed relationship
☐ engaged ☐ widowed ☐ divorced

If you are married, engaged, separated, or in a committed relationship, please indicate your significant other's name, age, and occupation:

____
____

If you have children, please indicate their names and ages:

first name	gender	age

first name	gender	age

Parents or parental figures

Name	Age	Living? (circle one)	Relationship status (circle one)
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D

Brothers and sisters in birth order

Name	Age	Living? (circle one)	Relationship status (circle one)
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D

Family of Origin

Were you reared by your blood parents? ☐ Yes ☐ No
Were your parents divorced? ☐ Yes ☐ No If yes, approximate year________________

Rate your parent's marriage: (unhappy) 1 2 3 4 5 6 7 8 9 10 (happy)

Religious background

Present denominational or faith group preference ________________________(i.e. Roman Catholic, Judaism, Baptist, etc…)
How important to you are spiritual matters? ___not ___little ___moderate ___very much
Where you raised within a religious group? ☐ Yes ☐ No

Interest in Therapy:

If you have been in therapy before, please describe briefly:

What brings you here? How long has this been going on?

What recurring patterns do you see in the way things go wrong?

What do you want to see happen as a result of the counseling?

How have you tried on your own to make things better? What did and didn't help?

Health Information

Date of last medical exam: ____________________
On average how many hours of sleep do you get a night? _________ hours.
On average, how many days a week/how long do you exercise? _____ days a week for _______minutes a day.
On average, how much alcohol do you consume during the week?_______________
Do you smoke?______ If yes, how much?_____________
Do you use street drugs and/or pharmaceuticals for recreational purposes? ☐ Yes ☐ No
Have you received help for drug or alcohol dependency? ☐ Yes ☐ No
When____________________________________ Where did treatment occur?_____________________
Have you been hospitalized for mental/emotional/psychiatric reasons? ☐ Yes ☐ No. If yes, when, where, and for what reasons:

____
____
____

If you are being treated for any other medical conditions not already mentioned, please identify them here:

____
____
____

If you are currently taking any medications related to depression, anxiety or any emotional or psychiatric difficulties, please name them and their purpose.

____
____

prescribing physician name:_____________________ psychiatrist name: _______________________

Have you ever had thoughts of harming yourself or someone else? ☐ yes ☐ no.
If yes, how recently? ____

Please provide any other information you think will be necessary or helpful

____
____
____
____
____

Signature____ Date __________________________

Insurance Information (if submitting)

We accept most Blue Cross/Blue Shield PPO plans. If you choose for us to submit a claim to your insurance, do we have your permission to file claims, treatment plans and have contact with your insurance? ☐ Yes ☐ No. If yes, please provide a copy of your current insurance card, driver's license and **sign here →**_____________________________