Susan Sabol, Psy.D. 2843 South County Trail, East Greenwich, RI 02818 401-884-9895

Client Questionnaire

Please take some time to complete this form so that I can know you better; use the back of the page if needed. If you do not feel comfortable completing any part of this, that's fine.

Name _____ Date _____ DOB _____

Please circle the symptoms which occur most frequently and/or are most troublesome to you:

Low energy/fatigue	Impulsivity	Feelings of shame
Restlessness	Compulsions	Difficulty going to work or school
Ruminations	Obsessions	Aggressive or rageful actions
Self-injurious behavior	Disorganized	Social Withdrawal
Anxious/fearful	Panic Attacks	Interpersonal rejection/sensitivity
Phobia(s)	Worrying	Feeling angry
Not caring anymore	Feeling numb	Depressed mood
Helplessness	Hopelessness	Excessive or inappropriate guilt
Tearfulness	Irritability	Loss of interest/pleasure
Low self-esteem	Distractibility	Marked mood shifts
Indecisiveness	Worthlessness	Diminished ability to think
Memory impairment	Flight of ideas	More talkative than usual
Pressured speech	Racing thoughts	Poor attention/concentration
Hallucinations	Paranoid thoughts	Disturbance in body perception
Binge eating	Increased appetite	Decreased appetite
Self-induced vomiting	Excessive exercising	Excessive use of laxatives
Nightmares	Jitteriness	Recurrent thoughts of distressing events
Early morning awakening	Excessive sleeping	Difficulty falling/staying asleep

General Information

Briefly state your reasons for seeking counseling at this time. What are your goals for therapy?

Who are the most emotionally supportive people now in your life?

What do you do for pleasure/leisure? How often do you exercise?

What are your strengths?

What do you do to cope with difficult situations, feelings?

Have you ever been arrested? Do you have any pending legal issues?

Were you in the military? List your rank, combat history, & discharge date.

Do you have financial concerns such as a lot of debt, inability to pay bills, etc.?

Do you have religious or spiritual beliefs that provide support and comfort to you?

Family Information

Please list the names and ages of the people living in your household, and your relationship to them; include children even if they're out of the house.

Please list the names and ages of the family in which you were raised and your relationship to them.

Please circle to indicate a family history of:

Bipolar Disorder Depression Anxiety Trauma Violence Psychosis Eating Disorder ADHD OCD

Alcohol or substance abuse Other addictive behaviors (gambling, shopping, etc.)

Suicide, suicide attempts, and/or self-injurious behaviors Homicide or homicide attempts

Where were you born and raised?

Have there been or are there currently any cultural or language issues for you?

Medical Health Information

Please list any troublesome or significant medical conditions you may have.

Please list the treating physicians or health care professionals involved in your present care.

Please list **all** current meds and dosages, including supplements and herbal remedies.

Current general health: _____ Excellent _____ Good _____Fair _____ Poor

Cigarette use: ___ No ___ < 1ppd ___ > 1ppd Any interest in quitting? ___Yes ___ No ___N/A

How healthy do you eat now on a 1-5 scale? (1 = v. unhealthy; 3 = average; 5 = very healthy) _____

How much caffeine (coffee, soda, tea, hot chocolate) do you consume per day? _____

Mental Health Information

Have you ever been seen by a mental health professional before? YES NO
If yes, please list who, when, and why.

Please list **all** past and current psychiatric medications and dosages.

Have you ever thought about or made a suicide attempt? If yes, when and by what means?

Are you currently thinking about suicide?

Are you having thoughts about seriously harming or killing someone else?

Have you experienced any other life-changing events or losses?

Education Information (Please check all degrees received)

High School Diploma ____ GED ____ Voc/Trade School ____ Associate's ____ Bachelor's ____

Master's ____ Doctorate ____ J.D. ____ M.D./D.O. ____ Other _____