



NEW CLIENT QUESTIONNAIRE

Welcome to Thriveworks! Thank you for taking a few minutes to fill out this form. The information you provide is confidential, and will be helpful for you and your counselor / coach when you meet for the first time. If you have any questions, just ask.

Today's Date _____

Name _____ Date of Birth ____/____/____

Address _____
Street city state zip

Phone (Primary) _____ (Secondary) _____

Email (please print clearly) _____

Ethnicity _____ Where did you grow up? _____

Education _____ Occupation _____ SSN _____

What is your religious background / involvement? _____

Emergency contact person (name, relationship, phone, address) _____

Closest Relationships (please list name, birth date, relationship, and whether they live with you)

Name	Birth Date	Relationship	Live with you?
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your current living arrangement (Alone? Live with others?) _____

Have you participated in any therapy before? Y____ N____ If yes, when? _____ Reason _____

Are you, currently seeing a psychiatrist, therapist, or helper? Y____ N____ If yes, Please list name, address, phone _____

Have you or a family member ever been hospitalized for mental or emotional illness? Y____ N____ If yes, please explain—dates, where, reason: _____

Substance use (Y/N, how much/day/week): alcohol _____ tobacco _____ marijuana _____
other _____

Substance abuse / addiction history? No _____ Yes (please explain) _____

Legal History (arrests, prison, DWI, parking tickets?) _____



Medical Information: Doctor's (Primary Care Physician) name and phone

May we contact your PCP, letting him / her know you've come to see us? (we do not release details other than your name, for referral purposes) Y____ N____

Are you taking any medications? Y____ N____ If yes, please list name/dosage/ reason

Allergies/adverse reactions (please list)

Major illnesses/surgeries/hospitalizations (please list w/dates and outcomes):

How can we help? Please tell us in your own words what brings you here today

What are your 2 most important goals for therapy?

1. _____
2. _____

Common problem/symptom checklist. Fill in: 0 - none, 1 - mild, 2 - moderate, 3 - severe.

___ marriage	___ divorce/separation	___ alcohol/drugs	___ God/faith
___ pre-marital	___ child custody	___ other addictions	___ church/ministry
___ being single	___ disabled	___ grief/loss	___ past hurts
___ sexual issues	___ work/career	___ depression	___ codependency
___ family	___ school/learning	___ fear/anxiety	___ intimacy
___ children	___ money/budgeting	___ anger control	___ communication
___ parents	___ aging/dependency	___ loneliness	___ self-esteem
___ in-laws	___ weight control	___ mood swings	___ stress control

Relationship Information:

Marital Status (check any that apply): Single ___ Dating ___ Committed relationship ___ Engaged ___

Married ___ Separated ___ Divorced ___ Widowed ___ (How long? _____)

Spouse's/Partner's Name (if applicable) _____ Age _____ Occupation _____



I would describe my friendships as: Close ____ Somewhat close ____ Distant ____ Conflicted ____

I would describe my relationship with my mother as: Close ____ Somewhat close ____ Distant ____ Conflicted ____

I would describe my relationship with my father as: Close ____ Somewhat close ____ Distant ____ Conflicted ____

Siblings: please list, indicate ages, genders, and describe your relationship _____

Crisis Information: Are you having any current suicidal thoughts, feelings or actions? Y ____ N ____

If yes, explain _____

Any current homicidal or violent thoughts or feelings, or anger-control problems? Y ____ N ____

If yes, explain _____

Any issues, hospitalizations, or imprisonments for suicidal or assault behavior? Y ____ N ____

If yes, describe _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Y ____ N ____

If yes, describe _____

Who referred you to us? _____

Is there anything else you would like us to know about you? _____

THANK YOU for taking the time to fill out this information sheet. This will be reviewed with you during your first counseling / life coaching session.

PLEASE SEE NEXT PAGE 7