Instructions: Clients, please take your time answering the following questions to assist your therapist in providing you with the best care possible. If your child is the client, please answer the questions regarding your child. If you are coming in for couples or family counseling, please answer the questions regarding the individual listed as the primary client (refer to therapist/front desk if you are unsure). If there are any portions of the questionnaire that you need further assistance with, your therapist will go over it with you during today's session. Thank you!

Medical Screening Questions

Have you ever had, or do you have any of the following health problems?

Yes	No		Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	Gastro intestinal	☐	☐	COPD
☐	☐	Diabetes	☐	☐	Acid Reflux/GERD	☐	☐	Tuberculosis
☐	☐	High Cholesterol	☐	☐	Gastritis/Ulcers	☐	☐	Seasonal allergies
☐	☐	Heart Problems	☐	☐	Liver Disease	☐	☐	Anemia
☐	☐	Migraine	☐	☐	Dialysis	☐	☐	Vitamin Deficiency
☐	☐	Seizures/Epilepsy	☐	☐	Thyroid Disorder	☐	☐	STD/STI
☐	☐	Stroke	☐	☐	Sleep apnea	☐	☐	Other:
☐	☐	Traumatic Brain Injury	☐	☐	Asthma	☐	☐	_____

Are you receiving treatment for these diagnoses? ☐ Yes ☐ No ☐ No longer an issue

What was the date of your last physical?

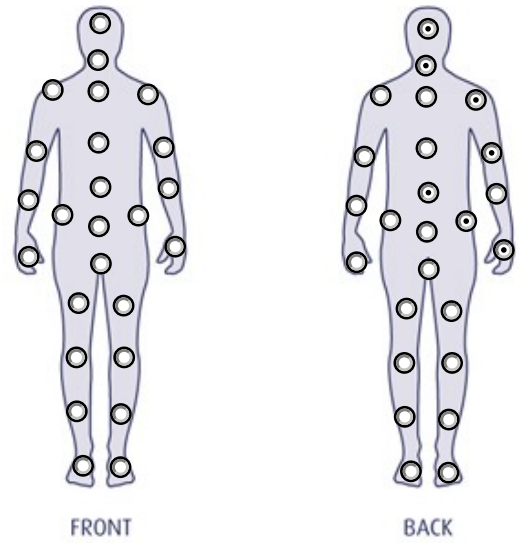
Would you like your therapist to talk to your doctor? ☐ Yes (see coordination of care form) ☐ No

On a scale of 0 to 10 with 0 being no pain, and 10 being excruciating pain, please rate your current pain level:

0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

If experiencing pain, is it already being treated by a doctor? ☐ Yes ☐ No

Place an X on each part of the body causing pain:



Please list all medications you are currently using:

Name of Medication	What condition is medication treating?

Surgeries:
Type of surgery and specific date or your age at surgery:

Hospitalizations:
Include medical hospitalizations, including dates and reasons for hospitalizations:

Allergies:
Please list any medication/environmental allergies:

Please complete this section for clients under the age of 18

Who does the client live with?
_____

Who is in the household?
_____

Who has legal custody of the client?_____

Were there any complications during pregnancy or delivery of the client?
☐ Yes ☐ No

If so, please explain: _____

Do you have any developmental concerns for the client?
☐ Yes ☐ No

If so, please explain: _____

Psychiatric Care Questions

Are you currently receiving services from a psychiatrist? ☐ Yes ☐ No If so, what is the name of your psychiatrist: _____			
Have you ever had a psychiatric hospitalization? ☐ Yes ☐ No			
If so: Dates: _____ Reason: _____			
Have you had thoughts of intentionally hurting someone else in the past 30 days? ☐ Yes ☐ No			
If so: Do you have a plan? ☐ Yes ☐ No			
Have you had thoughts of intentionally hurting someone else in your lifetime? ☐ Yes ☐ No			
Have you had thoughts of intentionally ending your life in the past 30 days? ☐ Yes ☐ No			
If so: Do you have a plan? ☐ Yes ☐ No			
Have you had thoughts of intentionally ending your life in your lifetime? ☐ Yes ☐ No			
Have you had any suicide attempts? ☐ Yes (Date_____) ☐ No			
Have you intentionally harmed yourself in the past 30 days? ☐ Yes (Method_____) ☐ No			
Have you ever been formally diagnosed with any of the following?	☐ Depression ☐ Anxiety ☐ Schizophrenia	☐ ADHD ☐ Bipolar Disorder ☐ Dyslexia	☐ Post-Traumatic Stress Disorder ☐ Intellectual Developmental Delay ☐ Other _____

Please note we are not a 24-hour crisis center, therefore if you are having thoughts about hurting yourself or someone else please dial the crisis hotline at 713-970-7000 or 911.

Nutritional Screening Questions

I normally eat:
☐ Once a day ☐ 2-5 times a day ☐ 6 + times a day

My appetite/food intake compared to 30 days ago is:
☐ Less ☐ Same ☐ More

My weight has gone up or down at least 10 pounds in the past 3 months:
☐ Yes ☐ No

Was this weight change intentional?
☐ Yes ☐ No

Are you trying to gain/lose weight?
☐ Yes ☐ No

Have you made yourself throw up in the past 3 months?
☐ Yes ☐ No

In general, do you eat past feeling full?
☐ Yes ☐ No

What is your level of physical activity?
☐ 0-1 times a week ☐ 2-5 times a week ☐ 6 + times a week

Do you have any food allergies?
☐ Yes ☐ No

If so, please list_____

Have you had any dental concerns (i.e. cavities, gum disease) during the past 3 months?
☐ Yes ☐ No

If so, please list_____

Have you sought treatment for these dental concerns?
☐ Yes ☐ No

Substance Use Questions

Do you Smoke? ☐ Yes ☐ No ☐ Former smoker	
If so which of the following substances do you smoke	☐ Tobacco ☐ Marijuana ☐ Other, please specify _____
How many per day? _____	Approximate age started_____ Approximate age stopped _____
Do you drink alcohol? ☐ Yes ☐ No ☐ Former drinker	
If so: How many days per week? _____ How many drinks per day? _____	Approximate age started_____ Approximate age stopped _____
Are you concerned about your alcohol, smoking or drug use?	☐ Yes ☐ No
Have you ever felt like you should cut down on your drinking, smoking and/or drug use?	☐ Yes ☐ No
Have people annoyed you by criticizing your drinking, smoking and/or drug use?	☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking, smoking and/or drug use?	☐ Yes ☐ No
Have you ever had a drink first thing in the morning to steady your nerves or rid yourself of a hangover?	☐ Yes ☐ No
Have you ever received treatment for drug or alcohol use? ☐ Yes ☐ No	
If so, was it ☐ Outpatient Treatment ☐ Inpatient Hospitalization	
Length and dates of treatment: _____	

Please note counseling services cannot be administered if the client is under the influence of any substance. If a referral is needed for substance use the clinician can provide a list of referrals.

Family History

Does anyone in your family have any substance abuse problems? ☐ Yes ☐ No
Does anyone in your family have any serious medical problems? ☐ Yes ☐ No
Does anyone in your family have any psychiatric problems? ☐ Yes ☐ No

_____

Name of Client (Printed) DOB Date

_____

Signature of Client (Client must be 18 years of age or older to sign)

_____

Signature of Parent or Guardian (If Client is under the age of 18) Relation to patient

If you would prefer not to electronically sign this form, you may print it out, sign the form, and bring it with you to your appointment.