Kindred Counseling, PLLC
Brittni Fudge, MA, NCC, LPCC
Client Questionnaire

Client's Name:_____Today's Date:_____

Address, City, State, Zip: _____

Home phone:_____Work phone:_____Cell phone: _____

Private email address:_____ May I email you at this email address? Yes/No

May I leave messages for you at home? Yes / No May I leave messages for you at work? Yes / No

Gender: M / F Age:_____ Birth Date:_____ Marital Status:_____

Others Living in Home (name, age, relationship to client):_____

_____

Highest Level of Education:_____Occupation:_____

Client's Employer: (optional)_____

Emergency Contact:_____Relationship to client:_____Phone:_____

Referred by (how did you hear about my services?):_____

Have you received previous counseling and/or substance abuse treatment? Yes_____No _____

If Yes, Name & number of therapist/Agency: (optional)_____

Past Diagnoses?_____Month /Years in treatment: _____

Name & number of psychiatrist or psychiatric nurse practitioner:(optional) _____

Any current medical or mental health conditions being treated? _____

Any current medications? Yes_____No _____

If yes, please list & include daily dose amounts_____

_____

Do we have your permission to discuss or receive treatment records and/or to receive diagnostic records from your past or current therapist, psychiatrist, and/or physician and/or to disclose or share our clinical information with your past or current therapist, psychiatrist, and/or physician? Yes No

Signature [required]_____**Date** [required]_____

Personal & Family Information

Ethnic identity & background_____Current relationship status_____

My birth parents are currently:

married/live together_____separated _____divorced_____never lived together_____
one or both deceased _____

Family of Origin [parents/step parents, adoptive parents, siblings]

Name (optional)	**Relationship to you**	**Age or deceased**

Current Family & Household [partner/spouse, roommates, children]

Name (optional)	**Relationship to you**	**Age or deceased**

Check all that apply:

History of:	You personally	Family of Origin
Counseling		
Alcohol Dependence		
Drug Dependence		
Chronic Physical illness		
Depression		
Anxiety		
Sexual Abuse and/or incest		
Psychiatric Hospitalization		
Suicide Attempts		
Eating Disorders or struggles		

Check all that apply:

I use alcohol: never_____less than once per week_____more than once per week_____daily_____

I use drugs: never_____less than once per week_____more than once per week_____daily_____

I use tobacco: never_____less than once per week_____more than once per week_____daily_____

I have experienced an unwanted sexual experience: recently_____ in the past_____
sexual assault___date rape_____rape___incest_____

My sleep is:_____hours a night Frequent waking? (y/n) Difficulty falling asleep? (y/n) Staying asleep? (y/n)

I am dissatisfied with my personal appearance (y/n)

I have felt like or tried to hurt myself in the past (y/n)

I'm currently hurting myself (y/n)

I have suffered a recent significant loss or death (y/n)

I have suffered a recent relationship ending (y/n)

I have suffered from a significant other loss (y/n) Please list: _____

I have experienced:

Past learning disability or attention deficit/hyperactivity disorder (y/n)

Permanent disability (y/n)
(if checked yes, please describe) _____

Legal difficulties (y/n)
(if checked yes, please describe) _____

Please state briefly your reasons for seeking services at this time:

_____

_____

_____

What do you think may be getting in the way of you resolving your current problems or concerns?

_____

_____

_____

What goals do you wish to achieve while in counseling?

_____

_____

_____

How would you like things to be different after you have participated in counseling/consultation?

_____

_____

_____