Client Questionnaire – for Marcia Newman, MA, LMFT

Thank you for taking the time to complete this information about yourself. Your honest responses are a very helpful tool in our work together. I look forward to working with you!

Name _____ Date of Birth _____ Age _____

Date of Initial Consult: _____ How did you hear about my services? _____

What would you like assistance with?

Do you have any other current issues or pressures?

Describe your CURRENT LIVING ARRANGEMENT (include names of household members, including any pets):

If applicable, list your SPOUSE'S / PARTNER'S name, age, and occupation. (If deceased, state date and cause of death):

Briefly describe how and when your present relationship began and the date you were married, if applicable:

If the above does not apply to you, are you presently involved in an intimate relationship?
Please list their name, age & occupation.

Describe strengths/problems in your relationship:

Do you have other intimate relationships from the past or present that would be important to know about? Please describe:

Describe any past marriage(s) and the reason(s) for your divorce. List your former spouse's name(s), marriage and year of divorce(s).

Do you have any children or stepchildren? If so, what are their names, ages, occupation & where they live. Briefly describe strengths & conflicts with each.
If any of your children are deceased, please state date & cause of death.

How many pregnancies of yours (or your partners) were terminated before birth?_____
Or given over for adoption?_____ List the approximate year and your age at the time.

FAMILY BACKGROUND

In what city/geographic area were you born?

In what city/geographic areas did you live in your childhood & adolescence?

Who raised you?

Provide both of your BIOLOGICAL PARENT'S names, occupations, marital status and where they live. (If they are or were divorced, state the approximate year). Include adoption, foster care, step-parents and/or other living arrangements you experienced.
Briefly describe your relationship with each (strengths/conflicts).

What types of issues concerned your parents and may have affected you? (Examples; chronic disease or episodic illness, alcoholism, depression, financial pressures, anxiety, workaholism, compulsive overeating, extra marital affairs, etc.)

If applicable, please list your BROTHERS & SISTERS; provide their names, ages, city location, occupations, if they are single, married, divorced & number of children. LIST YOUR SIBLINGS FROM OLDEST TO YOUNGEST AND INCLUDE YOURSELF IN THE BIRTH ORDER.
If your sibling is deceased, provide date & cause of death.
Briefly describe any strengths/conflicts with each sibling.

As a child who were you closest to in your family? Why?

Are you NOW close to anyone in your family? Please describe.

What is the ethnic-cultural background of your family (e.g., Jewish, Irish, English, Asian, etc.)?

Were you raised with a religion? State type/nature:

Has anyone ever touched you in a manner that was uncomfortable? If so, please describe.

How was anger and conflict handled in your family?

How would you describe your childhood and adolescence?

EDUCATION/EMPLOYMENT

Briefly list all the elementary, high school, technical, college or professional schools you attended (include the city location). List degrees received. Any significant school related experiences?

What did you learn about money while growing up? What was your financial status? How did you feel about it?

What is your current annual income range? How do you now feel about your income and your relationship with money?

Briefly describe your work history (including military service). List your most current or most recent employment first:

Describe any interest you may have in further education, training, or future work / career goals and/ or retirement goals:

PHYSICAL HEALTH

List any medications or natural supplements you are currently taking. Give purpose, name and daily dosage. If prescribed, please list your physician's name.

Have you experienced physical trauma including accident(s) and surgeries? If so, what & when?

In your past, have you consumed alcohol and other drugs? Did you feel it was ever a problem for you? Please describe:

Currently, do you consume alcohol and/or other non-prescription drugs? If yes, what and how much weekly and/or monthly?

Do you smoke cigarettes or any other nicotine products? If yes, how much?

Do you drink caffinated beverages? If yes, which ones and how much?

Do you experience discomfort because of your weight or eating habits? Please describe:

Are you on any type of exercise program? If yes, please describe:

How do you feel about your body? How do you feel about your expression of sexuality?

How many hours of daily sleep are you currently having? Is that an issue for you?

List any other health concerns:

SUPPORT SYSTEMS

Name of your primary physician (please indicate whether they are a M.D./.D.O./ N.D./ D.C./ A.P.) Please include their address and telephone number.

Have you had prior therapy, coaching or energy work? If so, was it helpful? List approximate year(s) and name(s) of therapist(s) or practitioners.

Do you see other health care professionals (i.e. chiropractor, massage therapist, acupuncturist, etc.)
If so, how often? Please list their names & locations.

Who do you rely on for emotional support?

What do you like to do to relax and have fun? Do you have difficulty relaxing and having fun? How often are you involved in these pleasurable activities?

Describe any fun activities, hobbies interests you would like to be involved with in the future?

Do you have any present religious, spiritual orientation, or teachings that you practice? Please describe. Do you spend quiet time with just yourself? If so, how often?

Are there any other important issues which you think would be important to discuss?

What do you hope to accomplish from our work together? How will you know when you have reached your goals?

Thank you for completing this questionnaire!
Please email to Marcia or bring this to your next consultation.