

Confidential Client Questionnaire, Family Therapy

Name:	Age:	Date:
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Please describe any significant current or past medical problems:

Please list any substances you currently use. Include any alcohol, prescription, non-prescription and over-the-counter medications and the dosage of each.

Have you had previous mental health and/or substance abuse treatment? Yes No

If yes, please give the name of the clinician(s), the months you saw them (e.g., Nov 06 - Feb 07), and the nature of the difficulty at the time.

Have you ever been hospitalized for a psychological difficulty? Yes No

If yes, please give the facility name, dates, and the nature of the difficulty at the time:

In your own words, what is the nature of the concern that you would like your family to address in therapy? Feel free to describe this in as much or as little detail as you wish. Use additional paper if you like.

