childguidance &familysolutions

Client #_____

Adult Client Questionnaire

Welcome. Thank you for choosing Child Guidance & Family Solutions. Please complete all of the information below. It is valuable and needed to better understand you as well as to meet the standards of our accrediting bodies.

CLIENT INFORMATION

Last Name_____ First Name_____ Middle Initial_____

Date of Birth:_____ Sex: ❑ F ❑ M Gender Identity ❑ F ❑ M ❑ Other _____

Social Security Number: _____

Home Address:_____ City:_____ Zip (+4):_____

County of Residence: _____ Highest Level of Education Completed:_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Preferred Method of Contact: ❑ Home ❑ Work ❑ Cell May we leave a message? ❑ Yes ❑ No

What is your current height and weight? Height _____ Weight_____

Marital Status: ❑ Divorced (date of divorce)_____ ❑ Unmarried couple (how long?)_____

❑ Married (date of current marriage)_____ ❑ Separated ❑ Never Married ❑ Widowed

Employment Status: ❑ Full-time ❑ Part-time ❑ Disabled ❑ Homemaker ❑ In the Armed Forces

❑ Not in Labor Force ❑ Retired ❑ Student

Race: ❑ Alaskan Native ❑ Native American ❑ Asian ❑ Black/African American

❑ Pacific Islander/Hawaiian ❑ Two or more races ❑ Unknown ❑ White/ Caucasian

Ethnic Origin: ❑ Not of Hispanic Origin ❑ Cuban ❑ Mexican /Mexican-American ❑ Other Hispanic

❑ Puerto Rican ❑ Unknown

Employer:_____ Occupation:_____

MILITARY/VETERAN STATUS (if applicable):_____

EMERGENCY CONTACTS

Who should we contact in case of emergency person? Contact person needs to be local.

Name	Relationship to You	Primary Phone #	Secondary Phone #

I give permission to contact the above people in case of emergency.

_____ _____

Signature **Date**

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Client #_____

PRIMARY INSURANCE INFORMATION: Bring Copy of Current Card(s)

Insurance Company: _____

ID#_____ Group/Contract # _____

Policy Holder Name: _____ Policy Holder Birthdate: _____

Policy Holder Address (if different from clients): _____

City: _____ State:_____ Zip:_____

Policy Holder Employer:_____ Policy Holder SSN#: _____

Relationship to the client: ❑ Self ❑ Spouse/Partner ❑ Mother ❑ Father ❑ Other: _____

SECONDARY INSURANCE INFORMATION: Bring Copy of Current Card(s)

Insurance Company: _____

ID#_____ Group/Contract # _____

Policy Holder Name: _____ Policy Holder Birthdate: _____

Policy Holder Address (if different from clients): _____

City: _____ State:_____ Zip:_____

Policy Holder Employer:_____ Policy Holder SSN#: _____

Relationship to the Client: ❑ Self ❑ Spouse/Partner ❑ Mother ❑ Father ❑ Other: _____

Are there any members of your household currently receiving services from Child Guidance & Family Solutions?

❑ Yes ❑ No

SPOUSE/PARTNER INFORMATION (if applicable)

Last Name_____ First Name_____ Middle Initial_____

Date of Birth_____ Sex: ❑ F ❑ M

Employment Status: ❑ Full-time ❑ Part-time ❑ Disabled ❑ In the Armed Forces

❑ Not in Labor Force ❑ Retired ❑ Student

PREVIOUS RELATIONSHIP/MARITAL INFORMATION (if applicable): _____

_____

_____

_____

CHILDREN:

Full Name	Living in your home (Y/N)	Birthdate	Sex

OTHERS IN THE HOME:

Full Name	Relationship

CURRENT LIVING ARRANGEMENTS:

❑ Homeowner ❑ Rent ❑ Friend's Home ❑ Relative's Home

❑ Supervised Group Home ❑ Crisis Residential ❑ Supervised Apartment ❑ Boarding Home

❑ Foster Adult Care ❑ Homeless ❑ Other_____

Are you experiencing any stress? ❑ No ❑ Yes, what type of stress and how often?_____

_____

_____

Have you ever had or are you currently having thoughts about hurting yourself? ❑ No ❑ Yes, when/how often?_____

_____

_____

Has violence ever been a concern in past or present relationships? ❑ No ❑ Yes, please explain_____

_____

_____

_____

_____

Client #_____

WHAT DO YOU HOPE TO GET FROM SERVICES HERE?_____

_____

_____

_____

_____

NUTRITIONAL INFORMATION

Do you eat balanced meals? ❑ No ❑ Yes **Do you skip meals?** ❑ No ❑ Yes

Have you experienced a change in appetite lasting 3 days or more? ❑ No ❑ Yes, an **INCREASE** in appetite

❑ Yes, a **DECREASE** in appetite

Have you experienced any unplanned or unusual weight loss or weight gain *(5 pounds in 1 month or 10 pounds in 6 months)*?

❑ No ❑ Yes, weight **LOSS**, how much? _____ ❑ Yes, weight **GAIN**, how much? _____

Do you have food cravings? ❑ No ❑ Yes, what?_____

Do you use tobacco? ❑ No ❑ Yes, How much?_____

Do you use alcohol? ❑ No ❑ Yes, what do you drink, how often, how much? _____

_____

_____

MEDICAL HISTORY

Have you had or currently have, any of the following problems?

	Thyroid Problems		Depression
	Diabetes		Anxiety Attacks
	Asthma		Hallucinations
	Dental Problems		Any other significant health concerns (explain)
	Food Allergies (list)		Other Allergies (list)

List any current medications. Include over the counter, herbals, and vitamins._____

_____

_____

_____

In the past, have you received counseling or psychotherapy from a counselor, psychologist, or social worker? ❑ No ❑ Yes (complete the following)

Year	Problem	Therapist/Agency Name	Medication

Psychiatrist Name and Phone (if applicable):_____

Psychiatrist Address (if applicable):_____

Primary Care Physician and Phone Number:_____

Primary Care Physician Address: _____

PHYSICAL EXAM HISTORY
List information about the last physical exam for yourself.

Date(s)	Physician's Name	Physician's Address	Recommendations made	Medication

List any medical problems that you are presently being treated for:

Date(s)	Medical Concern	Hospital/facility/Physician	Medication

List any Hospitalization/residential treatment history:

Date(s)	Hospital/facility	Medication

Are you experiencing any physical pain? ❑ No ❑ Yes

If yes, where and what are you doing to manage it?_____

_____

_____

I agree that the above is true and correct to the best of my knowledge.

_____ _____

Person(s) completing questionnaire Date

OFFICE USE ONLY – PLEASE LEAVE BLANK

For office use only:

BMI = _____

Physical health and nutrition information reviewed by:
❑ Psychiatrist ❑ Other Physician ❑ Nurse

_____
Signature Date

❑ Review completed, no further action is needed

Recommendation for referral to physical health services:
❑ Yes ❑ No

If yes, date letter sent to client and by whom:

_____
Name

Recommendation for referral for nutritional assessment:
❑ Yes ❑ No

If yes, date letter sent to client and by whom:

_____
Name Date