Phoenix Rising Solutions, LLC
to educate, empower, & enlighten

CLIENT THERAPEUTIC QUESTIONNAIRE

Please fill out this form and bring it to your first session along with Intake Information.

Name: ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years old)

____
(Last) (First) (Middle Initial)

Birth Date: ____/_____/____ Age: _____ Gender: ☐ Male ☐ Female ☐ ______________________

General and Mental Health Information

1. What has brought you into therapy at this time? (i.e., significant life changes, stressful events)

____

____

2. List any previously received mental health services (psychotherapy, psychiatric services, etc.)

____

____

3. List any prescription medications you are currently taking.

____

____

4. Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

   Please list and provides dates: ____

____

5. How would you rate the following using the scale below?

   1-Poor 2-Unsatisfactory 3-Satisfactory 4-Good 5-Very good

   If applicable, list any specific problems you are currently experiencing besides your rating:

   a. Physical health: ___ ____
   b. Sleep habits: ___ ____
   c. Eating habits: ___ ____
   d. Exercise habits: ___ ____

   What types of exercises to you participate in? ____

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General and Mental Health Information (continued)

6. Do you experience any chronic pain? What parts of the body?

____

____

7. Substance Use
   a. Do you drink alcohol more than once per week? ☐ Yes ☐ No
   b. Do you currently or have you in the past smoked cigarettes or cigars? ☐ Yes ☐ No
   c. Do you currently or have you in the past engaged in recreational drugs? ☐ Yes ☐ No

8. On a scale from 1–10 with 1 being most functional without symptoms and 10 being least functional with many symptoms. Where would you rate the following emotions
   (If applicable, also describe your symptoms in each area (emotional, physical, sensations, thoughts)

   a. Depression, sadness, grief, no motivation ______________________
   b. Anxiety, nervousness, panic, phobias, worry ______________________
   c. Anger, frustration, irritability, stressed ______________________
   d. Other: ______________________

Relationships

9. Are you currently in a romantic relationship? ☐ Yes ☐ No

   If yes, for how long: ____

   Rate your relationship on a scale of 1–10, with 1 being very poor to 10 being excellent: ____________

10. Do you have close friendships? Do you feel connected to others?

____

____

11. How are you involved in your community? If not, what would you like to do to become more involved?

____

____

Work / School Information

12. a. Are you currently employed or attending school? ☐ Yes ☐ No
    If yes, what is your current employment or academic situation:

    ____

    ____

    b. Do you enjoy work / school? Is there anything stressful about it?

    ____

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Family Mental Health History

13. In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

	Please Check	List Family Member
Alcohol/Substance Abuse	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Domestic Violence	☐ Yes ☐ No	
Eating Disorders	☐ Yes ☐ No	
Obesity	☐ Yes ☐ No	
Obsessive Compulsive Behavior	☐ Yes ☐ No	
Personality Disorder	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
Suicide Attempts	☐ Yes ☐ No	
Other	☐ Yes ☐ No	

Foundational Beliefs System

14. a. Do you consider yourself to be spiritual? ☐ Yes ☐ No
If yes, describe your belief (love of nature, mindfulness, mind-body, higher power, law of attraction):

____

____

____

14 b. Do you consider yourself to be religious? ☐ Yes ☐ No
If yes, describe your faith (Attends church, following a certain faith, prayer):

____

____

____

15. What do you consider to be some of your strengths?

____

____

____

____

16. What do you consider to be some of your weaknesses?

____

____

____

____

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Goals/Coping Methods

17. What would you like to accomplish in therapy? What would you like to work on?

____

____

____

18. What have you tried on your own to address your goals? (i.e., coping methods) What has worked or not?

____

____

____

Additional Information

19. Include any important information you would like to share with your therapist that was not asked on this form.

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