A Center 4 Change
Counseling and Psychotherapy

CLIENT QUESTIONNAIRE

Please complete the following questionnaire as each of these questions are a standard part of all initial services completed at A Center 4 Change. If you are in need for additional space, please feel free to you the back of the form or ask one of our staff for additional paper.

Client Demographics:

Client Name: ______________________________________ **Date of Birth:** _______________

Social Security Number: _____________________________ **Sex: M_____F___ Age:** _______

Marital Status: Single_____ Divorced_____ Separated_____ Widowed_____ Other ______

Address: ____

Phone Number: Home: ________________________ **Cell:** ____________________________

Height: ________________ **Weight:** _______________ **Race:** ___________________________

If you are completing this form for the client:

Name: ____ **Relationship:** ____________________

General Information:

Are you able to drive: Yes____ No____

Who drove you to this appointment? ____

Who were you raised by? ____

Where were you raised (city and state)? ____

Please list your siblings (include yourself) by age:

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Behavior History:

Does the client have:

- ☐ History of AWOL (running away/leaving without permission)
- ☐ History of suicidal threats or attempts
- ☐ History of gang/occult involvement
- ☐ History of cutting/self-mutilation
- ☐ History of bullying
- ☐ Use of weapons (or possession)
- ☐ History of psychosis
- ☐ History of stealing
- ☐ History of verbal or physical aggression
- ☐ History of sexually acting out
- ☐ History of substance abuse
- ☐ Legal issues/Court involvement
- ☐ History of fire setting
- ☐ History of suicidal thoughts or plan
- ☐ History of harm to animals
- ☐ History of threatening others
- ☐ History of substance abuse
- ☐ History of property destruction

Possible Problems/History:

- ☐ Number of previous placements ______
- ☐ Physically abused
- ☐ History of sexual abuse or exploitation
- ☐ Premature or low birth weight
- ☐ Failure to thrive
- ☐ Physical handicaps
- ☐ Allergies (Bee Stings)
- ☐ Medications Requirements
- ☐ Attachment Difficulties
- ☐ Eating Habits/problems
- ☐ History of trauma
- ☐ Other:________________________________
- ☐ Wetting, soiling, smearing
- ☐ Tunes out, withdraws, won't listen
- ☐ School difficulties
- ☐ Sleeping Difficulties
- ☐ Rocking, Head banging
- ☐ Developmental delays
- ☐ Hyperactive
- ☐ Lying
- ☐ Special nutritional needs
- ☐ Displays inappropriate sexual behavior
- ☐ Health needs

Familial Functioning:

Household Composition:

Number of people in household (including client): ________________________

Adults

Name	Relationship to client	Age

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Children

Name	Relationship to client	Age

Domestic Violence:

Is there a current Emergency Protective Order or Domestic Violence Order protecting any household member?

☐ Yes ☐ No If yes, please explain:

Has the client ever witnessed domestic violence? ☐ Yes ☐ No If yes, please explain:

Does client feel safe in his/her current living arrangement? ☐ Yes ☐ No If no, please explain:

Is there a history of physical, emotional or sexual abuse in the home? ☐ Yes ☐ No If yes, please explain:

Current Medications (Include Dosage and Frequency)	**Purpose of Medication**	**Physician**

Physical Health:

Has the client received medical care in the past year? ☐ Yes ☐ No If yes, please explain:

Does the recipient have any medical issues, such as diabetes, asthma, allergies, seizures, etc..? ☐ Yes ☐ No
If yes, please explain:

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Identify any current or past health problems, concerns, treatments, medications and/or disabilities:

Education Functioning:

What is the highest level of education the client has completed? ______________________________

Is or was the client in any special education classes? ______________________________

Has or did the client have to repeat any grades? ______________________________

Are there or where there any IEPs or 504 plans in place for the client? ______________________________

Does or did the client have behavioral problems in school? If yes, please explain in the space provided: _______

Substance Abuse:

Is there a history of substance abuse in the family?: ☐ Yes ☐ No

If yes, please explain if the client is or has been exposed to substance abuse:

Did mother use tobacco, alcohol, or drugs during the time she was pregnant with the client? ☐ Yes ☐ No

If yes, please identify what was used by the mother:

History of Client Substance Abuse:

Has client abused substances? ☐ Yes ☐ No

If yes, please complete the following sections.

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Client History of Substance Use:

	Substance you have used:	**Daily**	**Weekly**	**Monthly**	**Other**	**Last occasion of use?**
☐	Alcohol					
☐	Heroin					
☐	Pain Pills					
☐	Cocaine/crack					
☐	LSD/Acid					
☐	Tobacco					
☐	Sleeping Pills					
☐	Meth/speed/ecstasy					
☐	Valium/Xanax/downers					
☐	Marijuana/Hash					
☐	Glue/Solvent/Gas Huffing					
☐	PCP/Angel dust					
☐	Other:					

Describe history of client's substance abuse treatment:

Outpatient treatment
☐ Individual Counseling ☐ Group Counseling ☐ Family Counseling ☐ JSAP Program ☐ DSAP Program ☐ AA/NA
☐ Other:________________________ ☐ Other:________________________ ☐ Other:________________________

Inpatient treatment
☐ Short term residential treatment ☐ Long term residential treatment
☐ Detoxification
☐ Short term hospitalization

Does substance abuse effect social, family or educational functioning?

____ ________________________

Client/Responsible Party Signature **Date**