Client Questionnaire

LAKE CITY COUNSELING, LLC
2829 Royal Ave. Suite 200
Madison, Wisconsin 53713
608-661-2829

Client Name

1.Why are you seeking help for at this time? (Briefly describe specific problems)

2. Is anyone referring you? Referral Source:_____

3. Current symptom checklist:

__depressed mood
__lack of appetite
__social isolation
__feelings of worthlessness
__trouble staying asleep
__fatigue/low energy
__poor concentration
__mood swings
__agitated
__irritable
__grief
__hopelessness
__ suicidal thoughts
__ anger outbursts
__sleeping more than normal
__feelings of guilt
__feelings of wanting to harm yourself
__significant weight gain or loss
__excessively emotional
__panic attacks
__ obsessive thoughts
__overeating
__difficulty falling asleep
__ memory problems
__ flashbacks
__ manic episodes
__addictions (please specify)_____
__restless
__anxiety
__ other _____

4. Have you ever been in counseling before? ___ yes ____no

If yes, when, where and with whom? _____

5. Has any family member had mental health counseling or psychiatric treatment? ____ yes ____ no

If yes, who and why? _____

6. Do you have any medical problems? Accidents or Injuries? ___ yes ____no

If yes, they are: _____

7.Prior or current medication usage? ____ yes _____no If yes, please list (use back side if needed):

Medication	Dosage	Start date	End date	Physician	Beneficial?

8. As a child do you remember your needs being met (food, shelter, love?) If no, please describe:

_____

9. What strengths and/or experiences do you have to assist you?

_____