The Recovery Room Therapy Services
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Licensed Professional Counselor

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INFORMATIONAL QUESTIONNAIRE FORM

Client's Name_____ Date_____

Age_____ Gender__F __M Date of Birth_____

Form completed by (if other than client)_____ Relation to Client_____

Address_____

City_____ State_____ Zip_____ Phone

(Home)_____ (Work)_____ (Cell)_____

Where can we leave messages ____Work ____Cell ____Home

Email_____

Emergency Contact_____ Phone:_____

Primary reason(s) for seeking services:

____Sexual Trauma	____Domestic Violence (Victims)	____Relational and Interpersonal Skills
____Divorce/Blended Families	____Parenting Education/Consulting	____Anxiety/Phobias
____Depression	____Anger and Stress Management	____Grief and Loss
____Personal Growth	____Sexuality Struggles	____Academic Concerns
____Behavior Issues (Minors)	____Abandonment	

____Other Concerns_____

Family Information

Who Lives In Home

NAME	RELATION TO CLIENT	AGE
	SELF	

Marital Status (more than one answer may apply)

____Single ____Divorce in process ____Unmarried, living together
____Legally married ____Separated ____Divorced
____Widowed ____Annulment:
Total number of marriages_____
Assessment of current relationship (if applicable): ____Good ____Fair ____Poor

Parental Information

____Parents legally married ____ Parents have never separated ____ Parents never divorced
____Mother remarried Number of times____
____Father remarried Number of times____
____Not raised by biological parents (explain)_____

Family History of Mental Illness ____Yes ____No
If Yes,
Explain_____
_____

Family History of Substance Abuse____Yes ____No
If Yes,
Explain_____
_____

Personal Information

Development

Are there special, unusual, or traumatic circumstances that affected your development? ___Yes ___No
If Yes,
Explain_____

_____

Has there been history of child abuse? ___Yes ___No
If Yes, which type(s)? ___Sexual ___Physical ___Emotional ___Verbal
If Yes, the abuse was as a ___Victim ___Perpetrator
Other childhood issues: ___Neglect ___Inadequate Nutrition ___Other
If Other, please specify:_____

Social Relationships

Check how you generally get along with other people: (check all that apply)
___Affectionate ___ Aggressive ___Avoidant ___Fight/argue often ___Follower
___Friendly ___Leader ___Outgoing ___Shy/withdrawn ___Submissive
___Other (specify):
Sexual orientation: _____Comments: _____
Sexual dysfunctions? ___Yes ___No
If Yes, describe: _____
Any current or history of being a sexual perpetrator? ___Yes ___No
If Yes, describe:_____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong?
_____ Are you experiencing any problems due to cultural or ethnic issues? ___Yes ___ No
If Yes, describe: _____
Other cultural/ethnic information:_____

Spiritual/Religious

How important to you are spiritual matters? ___Not ___ Little ___Moderate ___Much
Are you affiliated with a spiritual or religious group? ___Yes ___No
If Yes, describe:_____
Were you raised within a spiritual or religious group? ___Yes ___No
If Yes, describe:_____
Would you like your spiritual/religious beliefs incorporated into the counseling? ___Yes ___No
If Yes, describe:_____

Legal

(Current Status)
Are you involved in any active cases (traffic, civil, criminal)? ___Yes ___No
If Yes, please describe and indicate the court and hearing/trial dates and charges:

_____

_____

Are you presently on probation or parole? ___Yes ___No

If Yes, please describe: _____

(Past History)

Traffic violations: ___Yes ___No DWI, DUI, etc.: ___Yes ___No

Criminal involvement: ___Yes ___No Civil involvement: ___Yes ___No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Education

Fill in all that apply: Years of education:_____ Currently enrolled in school? ___Yes ___No

Grade_____

Academic Concerns? ___Yes ___No

If yes,

described_____

_____

Behavioral Concerns? ___Yes ___No

If yes,

described_____

_____

___High school grad/GED

___Vocational: ___Number of years: Graduated: ___Yes ___No Major: _____

___College: ___Number of years: Graduated: ___Yes ___No Major:_____

___Graduate: ___Number of years: Graduated: ___Yes ___No Major:_____

Other training:_____

Special circumstances (e.g., learning disabilities, gifted):_____

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently: ___FT ___PT ___Temp ___Laid-off ___Disabled ___Retired ___Social Security

___Student ___Other (describe):_____

Military

Military experience? ___Yes ___No Combat experience? ___Yes ___No

Where: _____

Branch: _____Discharge _____

Date drafted:_____ Type of discharge:_____

Date enlisted:_____ Rank at discharge:_____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

___AIDS	___Dizziness	___Nose bleeds	___Alcoholism
___Drug abuse	___Pneumonia	___Abdominal pain	___Epilepsy
___Rheumatic Fever	___Abortion	___Ear infections	___Sexually transmitted diseases
___Allergies	___Eating problems	___Sleeping disorders	___ Anemia
___Fainting	___Sore throat	___Appendicitis	___Fatigue
___Scarlet Fever	___Arthritis	___Frequent urination	___Sinusitis
___Asthma	___Headaches	___Smallpox	___Bronchitis
___Hearing problems	___Stroke	___Bed wetting	___Hepatitis
___Sexual problems	___Cancer	___High blood pressure	___Tonsillitis
___Chest pain	___Kidney problems	___Tuberculosis	___Chronic pain
___Measles	___Toothache	___Colds/Coughs	___Mononucleosis
___Thyroid problems	___Constipation	___Mumps	___Vision problems
___Chicken Pox	___Menstrual pain	___Vomiting	___Dental problems
___Miscarriages	___Whooping cough	___Diabetes	___Neurological disorders
___Diarrhea	___Nausea	___ Other (describe):_____	

List any current health concerns:_____

List any recent health or physical changes:_____

Nutrition

Meal	How often (times per week)	Typical amount eaten
Breakfast	___ / week	___No ___Low ___Med ___High
Lunch	___ / week	___No ___Low ___Med ___High
Dinner	___ / week	___No ___Low ___Med ___High
Snacks	___ / week	___No ___Low ___Med ___High

Comments: _____

Prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? ___Yes ___No

If Yes, describe:

_____

_____

Most recent examinations	Date	Reason	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Most recent surgery

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other surgery

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Upcoming surgery

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family history of medical problems:

_____

_____

_____

Please check if there have been any recent changes in the following:

___Sleep patterns ____Eating patterns ___Behavior ___Energy level ___Physical activity level

___Weight ___Nervousness/tension ___General disposition

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours Yes	Used in last 48 hours No	Used in last 30 days Yes	Used in last 30 days No
Alcohol	_____	_____	_____	_____	___	___	___	___
Barbiturates	_____	_____	_____	_____	___	___	___	___
Valium/Librium	_____	_____	_____	_____	___	___	___	___
Cocaine/Crack	_____	_____	_____	_____	___	___	___	___
Heroin/Opiates	_____	_____	_____	_____	___	___	___	___
Marijuana	_____	_____	_____	_____	___	___	___	___
PCP/LSD/Mescaline	_____	_____	_____	_____	___	___	___	___
Inhalants	_____	_____	_____	_____	___	___	___	___
Caffeine	_____	_____	_____	_____	___	___	___	___
Nicotine	_____	_____	_____	_____	___	___	___	___
Over the counter	_____	_____	_____	_____	___	___	___	___
Prescription drugs	_____	_____	_____	_____	___	___	___	___
Other drugs	_____	_____	_____	_____	___	___	___	___

Substance of preference_____

Prior Treatment History

Counseling/Therapy ___Yes___No When_____Where_____
Suicidal Thoughts/Attempts ___Yes___No When_____Where_____
Drug/Alcohol Treatment ___Yes___No When_____Where_____
Psychiatric Hospitalizations ___Yes___No When_____Where_____
Self-Help Groups ___Yes___No When_____Where_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___Aggression	___Elevated mood	___Phobias/fears	___Alcohol dependence
___Fatigue	___Recurring thoughts	___Anger	___Gambling
___Sexual addiction	___Antisocial behavior	___Hallucinations	___Sexual difficulties
___Anxiety	___Heart palpitations	___Sick often	___Avoiding people
___Chest pain	___Hopelessness	___Sleeping problems	___Speech problems
___Cyber addiction	___Impulsivity	___Suicidal thoughts	___Depression
___Irritability	___Disorganized	___Disorientation	___Judgment errors
___Trembling	___Distractibility	___Loneliness	___Withdrawing
___Dizziness	___Memory impairment	___Worrying	___Drug dependence
___Mood shifts	___Eating disorder	___High blood pressure	___Panic attacks

Other (specify):_____

Briefly discuss how the above symptoms impair your ability to function effectively:

_____
_____
_____
_____
_____

Any additional information that would assist us in understanding your concerns or problems:

_____
_____
_____
_____
_____

What are your goals for therapy?

_____
_____
_____
_____Do you feel suicidal at this time? ___Yes ___No

If Yes,
explain:_____
_____
_____
_____

For Staff Use

Therapist's signature/credentials:_____ Date:____/____/____

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