Client	ID:	

Tess Cialdini, LCSW, LCAS **CLIENT QUESTIONNAIRE**

Please take a few minutes to complete this form. If you have any questions or don't know what to write, please feel free to leave the space blank until we meet.

Today's Date:					
Information About You:					
First Name:	Middle:			Last	t Name:
Date of Birth (mm/dd/yyyy):				·	
Phone Number(s) (home, cell, work):					
 Check here if it's ok for your therapist to call you here Check here if it's ok for your therapist to leave messages Check here if you would like to receive text reminders ab your next appointment 					
Street Address:					
City:	State:			Zip Code:	
Emergency Contact Name:	-		Relationship to You:		aship to You:
Emergency Contact Phone Number(s):					
Health Care Providers' Name(s)/Phone Number(s):					
Current Medications:					
Have you seen a counselor/therapist in the past? I Y I N (if yes, please provide the name or agency)		Are you currently seeing another counselor/therapist? \Box Y \Box N (if yes, please provide the name/agency and phone no.)			
If you have been in counseling or therapy in the past, what was helpful?					
What was not helpful?					

Age:		
Gend	er:	
1 2 3 4	Female Male Trans: [specify] Other: [specify] Ic/Cultural Background: African-American American Native/Alaskan Native 2a Tribal Member? □ Y □ N 2b Tribe:	Relationship Status: 1 Single 2 Married/Common Law/Domestic Partnership 3 Divorced 4 Widowed 5 Partner/Significant Other 6 Separated 7 Number of Children (please circle one):
3	Asian/Pacific Islander	0 1 2 3 4 5-7 more than 7
4 5 6 7 8	Latino/Latina/Hispanic Mixed Race [specify] White Other: [specify] Country of Origin: [specify]	Language Spoken in Home: 1 English
ъ.		2 Spanish 3 Chinese
1 2 3 4 5 6 7 Sexua 1 2 3 4 5 5 Veter Disab		## Japanese 5 Other: [specify
Other	· Information	<u> </u>
	lives in your home and what is their relationship to you?	
Who	Name Age	Relationship to you
1	175	
3		
3		
4 5		
3		

Please answer each of the following questions. However, feel free to leave blank those questions you do not wish to answer at this time. I may discuss some responses with you.

1	I Have you or anyone close to you had any recent changes, such as 10h loss, recent moves, etc. 7	□ Yes □ No
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2	Have there been any recent deaths or losses in your family or among your friends?			□ Yes □ No
3	Are you or is anyone close to you currently dealing with any medical concerns?			□ Yes
5	Have you ever participated in any support group and/or counseling – or considered being involved – due to your use or someone else's use of alcohol or other drugs?			□ Yes
6	Has any aspect of your life or those around you been negatively impacted at any time due to your use of alcohol or other drugs?			□ Yes
7	Has anyone ever expressed a concern about your use of alcohol or other drugs, including prescription medication and supplements?			□ Yes
8	Have you at any time in your life been concerned about your use of alcohol or other drugs, including prescription medication and supplements?			□ Yes
9	9 Do you have any concerns with your current diet, exercise patterns, or body type?			□ Yes
10	Are you currently, or have you ever, utilized self-harming behaviors (i.e., cutting yourself, banging your head, burning yourself) as a means of an emotional release or punishment, or for other reasons?			□ Yes
11	When gambling, have you ever felt the need to bet more and more money?			□ Yes
13	At any time during your childhood did you see or hear someone in your household being physically harmed?			□ Yes
14	Have you ever been emotionally mistreated in a significant and ongoing way by an intimate partner, such as being told you were ugly or stupid, or being restricted from activities that are very important to you?			□ Yes
15	Have you ever been made to have some form of unwanted sexual contact?			□ Yes □ No
16	Have you at any time felt afraid due to behavior by an intimate partner (e.g., spouse, boyfriend, girlfriend) or former intimate partner?			□ Yes
	Are you experiencing any difficulties in the following areas (please check all that apply):			
17	□ Appetite □ Body image concerns □ Breathing □ Concentration □ N	Depression/Sadness Dizziness/Faintness Headaches Memory Jightmares Numbness	 □ Pain management □ Sexual problems □ Sleep □ Stomach pains □ Stress management/Anxiety □ Weight loss or gain 	

Children in Therapy

Please list all minor children (under 18) who will be participating in therapy with you:	I have the legal right my relationship to th	Name of Child's School:		
	Custodial parent	Legal guardian	DHS or OYA caseworker	
	☐ Custodial parent	Legal guardian	☐ DHS or OYA caseworker	
	☐ Custodial parent	Legal guardian	☐ DHS or OYA caseworker	
	☐ Custodial parent	Legal guardian	☐ DHS or OYA caseworker	
	☐ Custodial parent	Legal guardian	☐ DHS or OYA caseworker	
	☐ Custodial parent	Legal guardian	☐ DHS or OYA caseworker	

Want To Understand The Following About You
Please describe your reason for seeking therapy at this time:
Who is involved and/or aware of these factors in your life?
Whatever your reason(s) for seeking counseling, how long has this influenced you/your life?
What have you tried to do to resolve these matters on your own? In what way(s) was this helpful?
What are your thoughts about how I might be of help?
Anything else I should know about you?
How were you referred to me? (please sheets)
How were you referred to me? (please check)
My website Treatment Facility Psychology Today Profile Another therapist (please list name)
From somewhere else (please list)