LAKE COOK BEHAVIORAL HEALTH

Client Questionnaire

Date:

Client Name:

Date of Birth:

Legal gender of client: Male ◯ Female ◯ (required for insurance)

Identifies as (optional): Male ◯ Female ◯ Non-Binary ◯

Pronouns (optional):

Name of person completing form (if different from above):

Relationship to client:

Emergency Contact: Name: Phone Number:

Marital Status: Never Married ◯ Married ◯ Divorced ◯

Separated ◯ Widowed ◯ Co-habitating ◯

Custody (if client is a minor): Mother ◯ Father◯ Joint◯

Present living arrangement: Alone◯ W/family◯ w/friends◯ w/Guardian◯ Foster Care◯

Other◯ Please describe:

Education: Please list highest level of education received:

Employment Status: Full-time◯ Part-time◯ Unemployed◯ Retired◯ Homemaker◯

Full-time Student ◯ Other◯ Please describe:

Occupation:

Military Service: Yes◯ No◯ If yes, please describe:

Psychological history and symptoms:

Briefly describe why you are seeking help at this time:

Describe any exceptional childhood events (e.g. achivements, divorce, illness, adoption, trauma):

Describe any exceptional school events (good or bad):

How much support do you receive from family, friends, and/or church?

Great deal◯ Some◯ Little◯ None◯

What community resources/self-help groups are you currently utilizing:

Describe current social activities (number of friends, play activities, recreational interests and hobbies):

Did you receive special education in school? Yes○ No○

Were/are there any problems or concerns with performance or behaviors at school/work? Yes○ No○

Are you experiencing financial problems: Yes○ No○

Do you have problems or concerns related to sexuality or your sexual orientation? Yes○ No○

Has a member of your family (immediate or extended) experienced an emotional problem? Yes○ No○

What do you believe to be your strengths?

What do you believe to be your weaknesses?

Psychological Symptoms:

Are you currently suicidal? Yes○ No○

Do you have a suicide plan? Yes○ No○

Suicidal thoughts only? Yes○ No○

Previous suicide attempt at any time? Yes○ No○

Are you currently engaged in aggressive/violent behavior? Yes○ No○

Do you have agressive/violent thoughts? Yes○ No○

Have you had aggressive/violent behavior or thoughts in the past? Yes○ No○

SYMPTOMS	CURRENT	PAST
Depressed Mood	☐	☐
Daily Irritability	☐	☐
Lack of interest/pleasure in activities	☐	☐
Increase in appetite	☐	☐
Loss of appetite	☐	☐
Difficulty sleeping or poor sleep	☐	☐
Decreased need for sleep	☐	☐
Increased need for sleep	☐	☐
Restlessness or inability to concentrate	☐	☐
Difficutly making decisions	☐	☐
Fatigue or loss of Energy	☐	☐
Feelings of worthlessness or guilt	☐	☐
Feelings of hopelessness	☐	☐
Recurrent thoughts of death	☐	☐
Racing thoughts or ideas	☐	☐
Distractibility	☐	☐
Rapid mood swings	☐	☐

Shortness of breath/dizziness	☐	☐
Accelerated heart rate or chest pain	☐	☐
Trembling/shaking	☐	☐
Excess fear of persons, places, animals, objects, situation	☐	☐
Difficulty controlling anger/bad temper	☐	☐
Psychological abuse	☐	☐
Sexual abuse	☐	☐
Distressing memories that reoccur or intrude	☐	☐
Recurrent distressing dreams	☐	☐
Do you hear or see things that others don't?	☐	☐
Delusions (unreasonable thoughts or beliefs)	☐	☐
Compulsive shopping/spending	☐	☐
Excessive computer/internet usage	☐	☐
Not able to control impulse to steal	☐	☐
Preoccupation with/or frequent gambling	☐	☐
Compulsive sexual behavior/sexual addiction	☐	☐
Sense of reliving traumatic events	☐	☐
Periods of time you cannot remember	☐	☐
Intense reactions to certain events or anniversaries	☐	☐
Avoidance of thoughts or feelings of trauma	☐	☐
Avoidance of activities or situations of trauma	☐	☐
Detachment from feelings, people and places	☐	☐
Sweating/feeling flushed	☐	☐
Choking	☐	☐
Nausea	☐	☐
Feeling Unreal	☐	☐
Numbness or tingling sensation	☐	☐
Fear of dying or going crazy	☐	☐
Binging/compulsive overeating	☐	☐
Intentional vomiting	☐	☐
Diuretics or laxative misuses	☐	☐
Excessive dieting	☐	☐
Compulsive exercising	☐	☐

CHEMICAL USE HISTORY

	Never	Rarely	Sometimes	Frequently	Almost always
After drinking or using drugs I have been unable to remember what happened the day before	☐	☐	☐	☐	☐
I experience physical discomfort that is relieved by alcohol or drug use	☐	☐	☐	☐	☐
I am able to drink or use more drugs than I used to without feeling an increased effect	☐	☐	☐	☐	☐
Does anyone in your family have a problem with alchohol or drugs? If yes, please explain:	☐	☐	☐	☐	☐

List any substances that you use and frequency (Tobacco, caffeine, alchohol, marijuana, cocaine, other)

HEALTH QUESTIONNAIRE:

1. What medical problems or concerns, if any, are you currently having?

a. Are those probelms being treated? Yes ○ No ○

b. If yes, by whom?

2. List any prescription or non-prescription drugs you are currently taking

or have taken in the last 6 months:

1.

2.

3.

4.

5.

6.

3. List any know allergies and reaction (drug, food, other)

1.

2.

3.

4.

5.

6.

	Current	Past
Tuberculosis	☐	☐
Chronic Bronchitits	☐	☐
Emphysema	☐	☐
Thyroid Disorder	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
Epilepsy (Convulsions)	☐	☐
Liver Disease	☐	☐
Ulcer (stomach) or Duodenus	☐	☐
Sexually Transmitted Disease	☐	☐
Kidney Disorder	☐	☐
High Blood Pressure	☐	☐
Pancreatitis	☐	☐
Heart Disease	☐	☐
Stroke	☐	☐
Jaundice	☐	☐
Asthma	☐	☐
Anemia	☐	☐
Multiple Sclerosis	☐	☐
Fibromyalgia	☐	☐
Chronic Fatigue	☐	☐
Other:	☐	☐

Do you have any disabling conditions? Yes ○ No ○

If yes, please describe:

Family history of serious illness, familial diseases:

List any past hospitalizations (including psychiatric), operations or serious illnessess with year of occurance and hospital/doctor:

1.

2.

3.

4.

Client Signature: Date:

Submit Cancel