Valerie Lumbley
MA, LPC

CONFIDENTIAL ADULT QUESTIONNAIRE

Client Contact Information

Client Name: _____

Address: _____

City/State/Zip: _____
Ok to send mail to this address? Yes No

Phone: _____
Ok to leave message at this number? Yes No

Email: _____
Ok to leave message via email? Yes No

Social Security Number (last 4 digits):_____

Date of Birth: _____

Emergency Contact: _____

Relationship: _____

Phone: _____

Who referred you to this office? _____
May I contact them to thank them for the referral? ____Yes ____No

Chief Complaint

Problems(s) and symptoms for which you are seeking counseling?

When did you begin experiencing these problems/symptoms?

How frequently do you experience these problems/symptoms?

On a scale of 1 to 10 (1 being least severe, 10 is most severe), where do you rate your presenting problems at this time?

What prompted you to seek counseling now?

Previous Treatment

Previous counseling or psychological treatment you have received in the past:
(Include hospitalizations for psychiatric reasons)

Date	Problem	Provider	Results/Reason for Ending Treatment

Medical History

How would you rate your present physical health? (circle one) Excellent Good Poor

Current prescription medications

Name	Dosage	Frequency	Date Began	Prescribing Physician

Medical Conditions	How Long	Treating Physician

Symptoms (circle all that apply)

Sleep Disturbance	Poor Concentration	Appetite Disturbance	Crying Spells
Low Energy	Depressed Mood	Mood Swings	Irritability
Anxiety	Panic Attacks	Phobias	Sexual Problems
Paranoid Thoughts	Hallucinations	Delusions	Aggressive Behavior
Oppositional Behaviors	Obsessions/Compulsions	Anorexia	Bingeing/Purging
Thoughts of Self-harm	Attempted Suicide	Thoughts of Harm to Others	

Others _____

Social History

Current Marital Status (Circle One) Single Engage Married Domestic Partner
Divorced Separated Widowed

Previous Marriages:

Education Completed (grade or degree):

Occupation:

Employer:

Military Service:

Any current legal issues?

Have you ever filed a complaint against a professional? If yes, please explain:

Any other information that could help the therapist not otherwise included here:

Crisis Information:

Are you having any current suicidal thoughts, feelings or actions? Y_____ N_____ If yes, explain

_____

Any current homicidal or violent thoughts or feelings, or anger-control problems? Y_____ N_____

If yes, explain _____

Any issues, hospitalizations, or imprisonments for suicidal or assault behavior?

Y_____ N_____

If yes, describe _____

Any current issues of significant loss or harm (illness, divorce, custody, job loss, etc.)? Y____ N___

If yes, describe _____

Who referred you ? _____

Emergency contact person (name, relationship, phone, address).

_____

_____

Is there anything else that you would like me to know about that you feel is pertinent?

_____ _____

Client Signature Date

_____

Printed Name

100 N. Central Expressway
Suite 402
Richardson,TX 75080