Sue E. Ouellette, LMFT

Please complete all of the following information to aid us in working with you.

Today's Date _____

Client Name: _____ Spouse/Partner Name: _____

Address: _____Town_____Zip_____

Telephone (Home): _____ (Cell):_____ DOB: _____

Marital Status: _____ Email address: _____

Employer: _____ Occupation: _____

Highest Level of Education Completed: _____

Current Spouse or Partner's Name	Age	Sex	**Previous Marriages or long term relationships; give beginning & end dates**		
Together since					
Children at home – Names	Age	Sex	**Children NOT currently with you – Names**	Age	Sex
1st					
2nd					
3rd					
4th					

MEDICAL HISTORY

Name of Primary Care Physician: _____ Phone #: _____
Address: _____

Current Medications:
Name_____ for _____ dosage_____
Name _____for _____ dosage_____
Name _____for _____ dosage _____
Name_____ for _____ dosage_____
Other: _____
Date of last physical exam _____ Allergies to any Medications? _____
Any physical problems at this time? Describe: _____
_____

Your estimation of your overall health: _____Excellent ____Good ____Fair ____Poor ____Very Poor
Serious illnesses and hospitalizations:_____
_____
Any current serious illnesses or hospitalizations in other family members? _____
_____

_____
Religious Affiliation if any Membership? Where do you attend?

_____
Religious Preference, if any

Role of Spirituality in your life

_____

_____

_____

MENTAL HEALTH HISTORY

Have you ever experienced any of the following?

Concern about your own use of alcohol or other drugs?	YES	NO
Concern about the use of alcohol or drugs by someone close to you	YES	NO
Had an unwanted sexual experience?	YES	NO
Experienced a violent or otherwise traumatic experience?	YES	NO
Have any family members hospitalized for mental health issues?	YES	NO

Have/had a family member who suffered from the following problems?

Anxiety/panic/nervousness	YES	NO	Alcohol or drug abuse	YES	NO
Depression	YES	NO	Schizophrenia	YES	NO
Bipolar Disorder	YES	NO	Other Mental Illness	YES	NO

MENTAL HEALTH HISTORY (Cont.)

Have you had previous counseling or therapy? YES NO

Name (s) of previous therapist(s):_____
_____

Reason treatment sought: _____
_____

Date (s) of treatment _____

Reason(s) for termination: _____
_____

Outcome _____

_____

Reason(s) for seeking therapy at this time – check all that apply

Anxiety/Nervousness	_____	Depression	_____	Fears	_____
Sexual problems	_____	Stress	_____	Work issues	_____
Anger	_____	Separation/loss	_____	Loneliness	_____
Feelings of Guilt	_____	Mid-life issues	_____	Aging issues	_____
Drug/Alcohol use	_____	Grief	_____	Self-esteem	_____
Insomnia/Trouble sleeping	_____	Suicidal thoughts	_____	Self control	_____
Nightmares	_____	Panic attacks	_____	Fatigue	_____
Distractible/unable to focus	_____	Memory issues	_____	Eating Problem	_____
Abuse: Emotional	_____	Abuse: Physical	_____	Abuse: Sexual	_____
Problem falling asleep	_____	Staying asleep	_____	Not enough sleep	_____
Problems making decisions	_____	Self-doubt	_____	Racing thoughts	_____
Apathy/lack of motivation	_____	Emptiness/Boredom	_____	Compulsions	_____
Panic Attacks	_____	Phobias	_____	Moodiness	_____
Obsessions	_____	Feelings of inferiority	_____		

Problems with spouse/partner	_____	Problems with children	_____	Financial concerns	_____
Problems with parents	_____	Problems at work	_____	Lack of friends/support	____
Poor Physical Health	_____	Legal problems	_____		

Any suicidal ideation, thoughts of harming yourself? _____
Any plan or intent to harm yourself? _____
Any means to harm self? Weapons in home, available? _____
Any previous attempts to harm self? _____
When/How/_____
_____

What do you hope to achieve in counseling/therapy? What are your goals and expectations?

_____
_____
_____
_____
_____
_____

FAMILY OF ORIGIN INFORMATION

Client's Family of Origin

Name (Father, Mother, Siblings)	Age	Sex	Describe your current relationship, ex, warm, close, distant, hostile	If deceased date and cause

Spouse or Partner Family of Origin

Name (Father, Mother, Siblings)	Age	Sex	Describe your spouse/partner's current relationship, see examples above	Deceased (date and cause)

Is there anything else you feel I should know, or you wish to share, before working together?

_____
_____
_____
_____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONAIRRE. YOUR ANSWERS GREATLY HELP ME TO BE OF BETTER HELP TO YOU.