New Client Questionnaire

Full Name: ____ Date: ________________

Address: ____

____

Telephone Numbers: Home: _____________________ Okay to call: Yes ___ No ____

Work: _____________________ Okay to call: Yes ___ No ____

Cell: ______________________ Okay to call: Yes ___ No ____

Email address: ____

Is it ok to contact you through email? Yes___ No___

Gender: Male ____ Female ____ Date of Birth: ______________ Age: _____

Marital Status: Single ____ Married ____ Separated ____ Divorced ____

Remarried ____ Widowed ____ Co-Habiting ____ Other _______

Occupation/Employer (if couple, please list each person's employer separately):

____

____

Please check highest educational level: Grade School ____ Middle School ____

High School ____ Some College ____ Bachelor's Degree ____

Master's Degree ____ Doctorate ____ Area(s) of study:

____

Religious Preference (if any):____

Person to contact in case of emergency: _____________________________________

Address: ____

Phone: ___________________________ Relationship: _______________________

Marital History (if never married, skip this section)

1st Marriage Beginning Date: ____________ Ending Date (if applicable): ___________

Name of Spouse: ____

Children & Ages: ____

____

Other Marriages: ____

Beginning and Ending dates:____

Children & Ages: ____

____

Please list the names & ages of all people currently living in your home.

Name	**Age/Birth Date**	**Relationship**

Who has custody of the minor children living in your home? _______________________

Medical History

Overall rating of physical health: Excellent Good Fair Poor

Date of last physical exam: ____

Name of Physician: __________________________________ Phone: ________________

Current Medical Conditions: ____

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History of Medical Conditions: ____

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____

History of Medical Hospitalizations: ____

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Please list name, dosage & length of time you have been taking any medications for any conditions you may have: ____

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Mental Health History

Are you currently under the care of a psychiatrist? Yes ____ No ____

Name of psychiatrist: ______________________________ Phone: _________________

Have you ever consulted a professional counselor before? Yes ____ No ____

Name of therapist: ________________________________ Phone: __________________

Dates: ____

Are you currently in therapy elsewhere? Yes ____ No ____

Have you ever had suicidal thoughts? Yes ____ No ____ Attempts? Yes____ No ____

If yes, please provide date(s) and treatment: ____________________________________

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Is there mental illness in your family history? Yes____ No____

If yes, please describe ____

____

____

History of Chemical Dependency/Treatment

Type of Dependency:____

Treatment Date(s): _______________________ Provider: _______________________

For what general areas of your life (marital, family, relationship, school, work, substance abuse, grief, anxiety, trauma, etc.) are you seeking assistance today?

Area 1: _________________ Area 2: _________________ Area 3: ________________

For each area you identified, what changes/improvements will be signs of progress?

Area 1: ____

Area 2: ____

Area 3: ____

What do you hope to accomplish today? _______________________________________

____

Circle any of the following that are presently causing you difficulty.

Assertiveness	Alcohol/Drug Use	Career Choices	Self-Concept
Parenting	Sexual Problems	Legal Matters	Religion
Nightmares	Loneliness	Marriage	Guilt
Anger/Temper	Concentration	Suicidal Thoughts	Relationships
Anxiety/Fears	My Thoughts	Decision Making	Relaxation
Trust	Divorce	Depression/Sadness	Shyness
Stress	Friends	Dating	Memory
Inferiority	School/Education	Unhappiness	Finances
Confusion	Fatigue	Family	Food Issues
Work	In-Laws	Abuse	My Past

Please review the items you circled and put an asterisk* by the **3** areas that are causing you the **most** difficulty at this time.

Please provide any additional information that you think may be useful.

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Sonja Fulmer Counseling - Practice Policies

FEE POLICY:
The fee for counseling services is set at $110 per 50 minute session
I request that cancellation be made 24 hours in advance; otherwise, you will be financially responsible for the session.
Other services such as court appearances, inpatient visits, or significant telephone counseling, etc. are based on the session rate in addition to transportation/travel expenses. Payment for service is expected at the time of each service. Please note that clients who choose to file insurance under "out of network benefits" are still expected to pay the full fee for services at each visit. I do not file any insurance claims, and do not assess for disability of any type.
CONFIDENTIALITY:
The State of Tennessee provides that client information is confidential and will not be shared without your written consent unless required by the following three statutes:
• Any suspected child or elder abuse is required to be reported to the appropriate governmental authorities.
• If there is reason to believe that the client is in imminent danger to him/herself or to any other individuals, I am required by law to report this to the appropriated authorities as well as to warn any individuals who may be threatened.
• When a client is involved in legal proceedings, client records may be subpoenaed.
PROFESSIONAL SERVICES:
I am available for counseling appointments at selected times throughout the weekday with limited evening appointments.
You may leave a voice mail message at my office number (615-373-7175) at anytime and I will receive the message at my earliest convenience. If you are unable to reach me and you have an emergency, please call the Crisis Line at 615-244-7444 or go to your local emergency room.
BENEFITS AND RISKS OF COUNSELING:
Persons contemplating counseling should realize that they may make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may also make changes in their marriages or significant relationships, such as with parents, friends, children, relatives, etc. They may change employment or other aspects of their lives. While I will assist the client in effecting change, I cannot guarantee a specific outcome. Clients are ultimately responsible for their own growth.
CREDENTIALS:
I hold an M.A. degree in Counseling from Trevecca University and am licensed in Tennessee as a Professional Counselor with Mental Health Service Provider designation.

Do you have any questions about fees, confidentiality or other matters? Yes____ No____
Do you agree to the conditions and provisions of the Practice Policies? Yes____ No____

Signature: ____ Date:________________

Signature: ____ Date:________________