Name: ___________________________________

Associated Christian Therapy Services

Client History Questionnaire

1.) **Current Symptoms:** Please check any of the following that you have experienced recently.

- ❑ Aggressive Behavior
- ❑ Anger
- ❑ Anxiety
- ❑ Avoid People
- ❑ Blended Family Issues
- ❑ Can't Have Fun
- ❑ Can't Relax
- ❑ Communication Problems
- ❑ Compulsive Behavior
- ❑ Constipation
- ❑ Crying Easily
- ❑ Death of a Loved One
- ❑ Decreased Sex Drive
- ❑ Delusions
- ❑ Depression
- ❑ Diarrhea
- ❑ Dizziness
- ❑ Driven
- ❑ Family Problems
- ❑ Family Violence
- ❑ Fearful
- ❑ Financial Problems
- ❑ Guilt
- ❑ Hallucinations
- ❑ Headache
- ❑ Health Problems
- ❑ Hearing Voices
- ❑ Hopelessness
- ❑ Hyperactivity
- ❑ Hyperventilation
- ❑ Impulsive
- ❑ Increased Appetite
- ❑ Indecisiveness
- ❑ Irritability
- ❑ Lack of Interest
- ❑ Loneliness
- ❑ Low Energy
- ❑ Low Self-Esteem
- ❑ Mood Swings
- ❑ Nightmares
- ❑ Obsessive Thoughts
- ❑ Panic Attacks
- ❑ Paranoia
- ❑ Parent-Child Conflict
- ❑ Perfectionism
- ❑ Personality Changes
- ❑ Phobias
- ❑ Physical Abuse
- ❑ Poor Appetite
- ❑ Poor Attention Span
- ❑ Poor Sleep
- ❑ Relationship Problems
- ❑ Seeing Things
- ❑ Sexual Abuse
- ❑ Sexual Problems
- ❑ Shaky
- ❑ Stress
- ❑ Suicidal Feelings
- ❑ Weakness
- ❑ Weight Gain
- ❑ Weight Loss
- ❑ Work Problems
- ❑ Worry a lot
- ❑ Other_______________

2.) **Symptoms have been present for**: Less than 1 month 1-6 months 7-11 months more than a 1 year

3.) **Previous Treatment**: Pastoral Counseling Hospital Professional Counseling

Treated for ________________________ Treated by ________________________ When _____________

4.) **Counseling History** (Please include all prior inpatient and outpatient treatment. Also include responses to medications) ____

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5.) **Medical History** (previous illness, medications with dose, current physical problems and family history) ____

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Physician's Name: ____________________________ Date of last physical exam _________________

(PLEASE COMPLETE BOTH SIDES)