



To help us address your needs and concerns, please complete a separate questionnaire for each person participating in therapy. Please answer honestly; all information will be kept confidential.

For children under 12: 1) parent(s) complete a questionnaire for themselves and answer all questions as they pertain to **you**, not your child; 2) please fill out **only the first two pages** of a separate questionnaire as they pertain to your child.

Client Information

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ (Home, Work, or Cell?) Leave message: __Y__N

Alternate Phone: _____ Email: _____

Date of Birth: _____ Gender: _____ Male _____ Female Ethnicity: _____

Status: __Married__ __Single__ __Divorced__ __Widowed__ __Separated__ __Partnered__

__Other (specify) _____ Years in Relationship: _____

Client is:

__TTUHSC Student__ __Spouse of HSC Student__ __Child of HSC Student__ __Other (list) _____

__Employee__ __Spouse of Employee__ __Child of Employee__ __Other (list) _____

Family Members (in household):

Name: _____ Age: _____ Relationship to Client: _____

Name: _____ Age: _____ Relationship to Client: _____

Name: _____ Age: _____ Relationship to Client: _____

Name: _____ Age: _____ Relationship to Client: _____

Name: _____ Age: _____ Relationship to Client: _____

Previous Client? ____Yes ____No If yes, counselors name: _____

How did you learn about the Counseling Center? _____

Were you mandated to receive counseling? __Yes__ __No__

In case of emergency, whom should we contact?

Name: _____ Phone: _____

Primary Physician: _____

Please list **ALL MEDICATIONS** you are taking below, *including non-prescription medications*:

Name of Medication	Dosage	Prescribing Doctor	When Began	Reason Taking

Benefit Information

Please provide information for the person with EAP or PAS benefits. If more than one person in the household has benefits, please check that program as well.

EAP Program:

- | | | |
|---|--|--|
| <input type="checkbox"/> TTU | <input type="checkbox"/> PYCO Industries | <input type="checkbox"/> UMC |
| <input type="checkbox"/> TTUHSC | <input type="checkbox"/> Shallowater ISD | <input type="checkbox"/> UMC Physicians |
| <input type="checkbox"/> Citibus | <input type="checkbox"/> Shropshire Agency | <input type="checkbox"/> United Way Agency |
| <input type="checkbox"/> City of Lamesa | <input type="checkbox"/> Slaton ISD | (Communities in Schools, WPS, Catholic |
| <input type="checkbox"/> City of Lubbock | <input type="checkbox"/> South Plains College | Family Services, Legal Aid, |
| <input type="checkbox"/> Lubbock Cooper ISD | <input type="checkbox"/> South Plains Electric | BB-BS, Casa) |
| <input type="checkbox"/> LISD | <input type="checkbox"/> Standard Sales | |
| <input type="checkbox"/> Poka Lambro | <input type="checkbox"/> TT Federal Credit Union | |

Status: Full Time Part Time Other **Years Employed:** _____

PAS Program:

- | | |
|---|---|
| <input type="checkbox"/> School of Medicine | <input type="checkbox"/> School of Health Professionals |
| <input type="checkbox"/> School of Pharmacy | <input type="checkbox"/> Graduate School of Biomedical Sciences |
| <input type="checkbox"/> School of Nursing | |

Status: Full Time Part Time Other **Years in Program:** _____

Client Wellness

Current Concerns: What problem(s) do you want help with in counseling? For each problem you identify, please state *when the problem began* and *how distressed* you have been by that problem.

Concern	When began?	A little	Moderate	Quite a bit	Extremely
1.		1	2	3	4
2.		1	2	3	4
3.		1	2	3	4

Range of Problems: In the past month, how **troubled** were you by each of the following (*circle the number*):

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Medical Problems	0	1	2	3	4
Employment Problems	0	1	2	3	4
Family Problems	0	1	2	3	4
Psychological or emotional Problems	0	1	2	3	4
Legal Problems	0	1	2	3	4
Financial Problems	0	1	2	3	4
Alcohol Problems	0	1	2	3	4
Drug Problems	0	1	2	3	4
Tobacco use Problems	0	1	2	3	4
Chronic Pain Issues	0	1	2	3	4
Weight Issues	0	1	2	3	4
Suicidal Thoughts	0	1	2	3	4
Thoughts of harming someone else	0	1	2	3	4

Life Satisfaction: At the present time, how satisfied are you with these areas of your life (*circle the number*):

	Extremely Dissatisfied	Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Satisfied	Very Satisfied
Work and/or Studies	1	2	3	4	5	6
Leisure time activities	1	2	3	4	5	6
Love and intimate relationships	1	2	3	4	5	6
Other Interpersonal relationships	1	2	3	4	5	6
General sense of happiness	1	2	3	4	5	6
Progress towards personal goals	1	2	3	4	5	6

Behavioral Health:

Do you drink alcohol? ___Yes ___No If yes, what do you drink? _____

How often do you drink? _____ How much? _____

Do you drink more than you use to? ___Yes ___No

Has anyone objected to your drinking? ___Yes ___No

Do you use drugs? ___Yes ___No If yes, which drug(s) do you use? _____

How often do you use drugs? _____ How much? _____

Do you use drugs more now than you use to? ___Yes ___No

Has anyone objected to your drug use? ___Yes ___No

Have you ever struggled with an eating disorder (*anorexia, bulimia, etc.*)? ___Yes ___No ___Not sure

If yes, which one(s)? _____ When? _____ How long? _____

Have you ever engaged in self-harm (*cutting, burning, etc.*)? ___Yes ___No

If yes, what kind(s)? _____ When was last occurrence? _____

Who do you consider to be in your support system? (please check all that apply)

___spouse/partner ___immediate family ___extended family ___close friend ___group of friends

___faith group ___12 step program ___other (*specify*) _____