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CLIENT INFORMATION

Your cooperation in completing this questionnaire will be helpful in planning my services to you. Please answer each item carefully or ask for clarification if you do not understand an item.

Clients

Full Name: _____ Today's Date: _____

Address: _____

Street

City

State

Zip Code

Telephone: _____

(home)

(work)

(cell)

Age: _____ Date of Birth: _____ Marital Status: _____

Occupation: _____

Employer: _____

Education: _____

Spouse (or significant other)

Name: _____ Date of birth: _____ Age: _____

Occupation: _____ Employer: _____

Telephone: _____

(work)

(cell)

If client is a minor:

School: _____ Grade: _____

Father's Name: _____ Mother's Name: _____

Father's Address: _____ Mother's Address: _____

Father's Phone: _____ Mother's Phone: _____

(home)

(home)

(work)

(work)

If parents of minor child are separated or divorce, please describe living arrangements and decision-making Arrangements (Custody):_____

Parental Access Schedule:_____

Briefly describe your reasons for seeking help:_____

Who referred you?:_____

When was client last examined by a physician?:_____

List any major health problems for which client currently receives treatment:_____

List any medications currently being taken:_____

Has client ever received psychiatric or psychological help or counseling of any kind?_____

If so, please explain:_____

Has there been any history of:
Violence_____, Sexual Abuse_____, Suicidal Thinking_____, Suicide Attempts_____

Drug use_____, Alcohol use_____

If so, please explain:_____

Please circle any of the following which pertains to client.

- | | | | |
|-----------------|----------------------|------------------|----------------|
| Nervousness | Depression | Fears | Shyness |
| Sexual Problems | Suicidal thoughts | Separation | Divorce |
| Anxiety | Drug use | Alcohol use | Friends |
| Anger | Self-control | Unhappiness | Sleep |
| Stress | Work or school | Relaxation | Headaches |
| Tiredness | Legal matters | Memory | Ambition |
| Energy | Insomnia | Making decisions | Violence |
| Loneliness | Inferiority feelings | Concentration | Education |
| Career choices | Health problems | Intimacy | Temper |
| Nightmares | Marriage | Bowel Problems | Being a parent |

List the members of your family and all others living in your home:

Name(s)	Age/Birth Date	Relationship	Occupation/Grade

Please add any additional information which you feel may be useful for me:

Your signature

Thank you for completing this questionnaire.

