Leanne Morris, MSW

CONFIDENTIAL CLIENT QUESTIONAIRE

Please fill out this form and bring it to your first session. All information you provide here will remain confidential.

Name:____

Mailing
Address:____

Phone Numbers:

Home: ___________________________ May I call you here? Yes No

Cell: _____________________________ May I call you here? Yes No May I text you here? Yes No

E-mail: ____ May I email you? Yes No

Birth Date: ______ /______ /______ Age: ________

Relationship Status: Single Partnered Married Separated Divorced Widowed

Please list any children/age: ____

Emergency Contact Name: _________________________________ Number: ________________________

Please circle any of the following that you are experiencing:

Anxiety	Depression	Panic Attacks	Fears/Phobias
Grief	Sexual Challenges	Suicidal Thoughts	Relationship Challenges
Financial Difficulties	Drug/Alcohol Use	Work Stress	Self-Control Difficulties
Anger	Mood Swings	Spiritual Issues	Recurring Memories/PTSD
Life Transition	Health Problems	Parenting Challenges	Cutting/Self-Harm
Fatigue	Apathy	High Sensitivity	Appetite/Weight Change
Disturbing Thoughts	Low Self Image	Change in Personality	Eating Issues

Other:____

How would you describe your sleep?
Poor Unsatisfactory Satisfactory Good Very good

How often do you often recall your dreams? Never Rarely Monthly Weekly Daily

How would you describe your current physical health?
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

Are you currently taking any prescribed medications? If yes, please identify the medications.

Have you been under the care of a psychiatrist, psychologist, or therapist? Y / N If yes, please briefly explain the circumstances:

Have you ever been hospitalized? Y / N If yes, please give the date and briefly explain the nature of the problem that required attention:

Are there other alternative therapies you are receiving regularly (massage, acupuncture)?

Do you have a history of childhood trauma or abuse/neglect? Yes No Maybe

How often do you drink alcohol? Never Rarely Monthly Weekly Daily

How often do you engage in recreational drug use? Never Rarely Monthly Weekly Daily

Have you ever had thoughts of suicide? Frequently Sometimes Rarely Never

How would you describe your spiritual life?
Poor Unsatisfactory Satisfactory Good Very good

Do you consider yourself highly sensitive? Yes No Maybe

What significant life changes or stressful events have you experienced in the past few years?

How do you usually take care of yourself when your life feels out of balance?

What are your goals for our work together?

How did you hear about my practice?

Is there any additional information you think it would be helpful for me to know as we begin to work together (feel free to use the back of this sheet)?