Building Blocks Counseling | New Client Questionnaire

Client Name: **Date:**

Have you ever participated in any kind of counseling or therapy before, including any current involvement? _____ Yes _____ No

Provider	Dates	Issues Addressed	Benefit Received/Effectiveness
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been hospitalized, or received in-patient treatment for substance abuse/chemical dependency, or any behavioral or mental healthy issues? _____Yes _____ No.

Provider	Dates	Issues Addressed	Benefit Received/Effectiveness
_____	_____	_____	_____
_____	_____	_____	_____

Legal Issues (List any contact with the legal system, current or historical.)

Arrest/Charge	Date	Disposition
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have a probation/parole officer? _____ Yes _____ No.

Name: _____ County/Jurisdiction: _____ Phone: _____

Would you like your primary care doctor to be notified of your visit with me? _____ Yes _____ No

If Yes, Name, Address, Phone, Fax: _____

Are you currently on any medications of any kind? _____ Yes _____ No. If yes, please list and indicate what they are being used to treat.

_____

_____

Are you currently having any suicidal thoughts, feelings or actions? _____ Yes _____ No.

If yes, please explain: _____

Are you currently having any homicidal or violent thoughts or feelings, or anger-control problems? ? _____ Yes _____ No.

If yes, please explain: _____

Have you ever had any issues, hospitalizations, or imprisonments for suicidal, homicidal or assaultive behaviors? ? _____ Yes _____ No.

If yes, please explain: _____

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Are you currently under any kind of threat or stress related to loss or harm? (illness, divorce, custody, job loss, etc.)? ? _____ Yes _____ No.

If yes, please explain: _____

Substance Abuse Screening and Assessment

Do you currently use any illegal substances? _____ Yes _____ No (If yes, provide more detail below.)

Have you ever used any illegal substances? _____ Yes _____ No (If yes, provide more detail below.)

Do you currently abuse or misuse any prescription medications? _____ Yes _____ No (If yes, provide more detail below.)

Have you ever abused or misused prescription medications? _____ Yes _____ No (If yes, provide more detail below.)

Do you currently use alcohol? _____ Yes _____ No (If yes, provide more detail below.)

Have you ever used alcohol? _____ Yes _____ No (If yes, provide more detail below.)

Have you ever felt that you use too much alcohol or other drugs? _____ Yes _____ No

Have you tried to cut down or quit using alcohol or other drugs? _____ Yes _____ No

Have you gone to anyone for help because of your drinking or drug use? (AA, NA, CA, Celebrate Recovery, Counselors, Treatment Programs) _____ Yes _____ No

Have you experienced any health problems, related to drinking or drug use? _____ Yes _____ No

____ Blackouts/Memory Loss

____ Injured your head after/during drinking or using

____ Convulsions/Delirium Tremens (“DTs”)

____ Hepatitis/Liver Problems

____ Felt Sick, shaky or depressed when you stopped

____ Felt “bugs” or a crawling feeling under the skin

____ Used needles to shoot drugs

____ Suffered physical injuries as a result of drinking or using

____ Other: _____

Has drinking or other drug use caused problems between you and your family or friends? _____ Yes _____ No

Has drinking or other drug use caused problems for you at school or at work? _____ Yes _____ No

Have you been arrested or had other legal problems? (bouncing bad checks, DWI, theft, possession) _____ Yes _____ No

Have you lost your temper or gotten into fights while drinking or using? _____ Yes _____ No

Do you need to drink or use more, or more frequently, to get the effect you want? _____ Yes _____ No

Do you spend a lot of time thinking about or trying to get alcohol or other drugs? _____ Yes _____ No

When drinking or using drugs, are you more likely to do something you wouldn’t normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex? _____ Yes _____ No

Do you feel bad or guilty about your drinking or drug use? _____ Yes _____ No

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Have any of your family members ever had a drinking or drug problem? _____ Yes _____ No

Do you feel that you have a drinking or drug problem now? _____ Yes _____ No

What tends to trigger your drinking or drug use? _____

What is most helpful to you in maintaining sobriety? _____

Below, please list any and all substances you currently use, or have ever used, providing as much information as you can.

Drug/Substance	First Used	Last Used	Frequency	Amount	How Used (Smoke, inject, etc.)

Anything else you would like for us to know about you?

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Completed by: _____Wesley Perdue, MS