UNITYPOINT EMPLOYEE ASSISTANCE/STUDENT ASSISTANCE PROGRAM
Individual Client Information Questionnaire

Your cooperation in completing this questionnaire will be helpful in planning your services for you. Please answer each item carefully or ask your therapist for clarification if you do not understand an item. Please print all answers. Thank you.

Today's date: _____

Last Name: _____ First: _____ Initial: _____

Home Phone: (____) _____ Work: (____) _____ Cell Phone: (___)_____

Email: _____

Occupation: _____ Place of Employment: _____

School: _____

Date of Birth: _____ Age: _____ Gender: _____

Marital Status: _____ If presently married, for how long? _____

Children? Y/N Age: _____ Male or Female : _____

Name of Spouse: _____ Spouse's Occupation: _____

Have you been married previously? Y/N _____

Your Education: K 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 _____
Highest Degree

Briefly describe your reason for seeking help or the circumstances which brought you to our office:

_____

_____

_____

Who referred you to us or suggested that you contact us? _____

Have you had (or do you have) any major medical or mental health problems for which you currently receive treatment or which significantly affect your life? If so, please describe:

_____

_____

List any medications you are now taking:

_____

Name of your personal physician: _____

Please Complete Entire Questionnaire

Have you ever received psychological or psychiatric help or counseling of any kind before? If yes, please give details, including dates or time period of your previous treatment:

_____

_____

_____

How would you rate your previous help? Very Helpful Somewhat Helpful Not very Helpful Useless Harmful

Please draw a circle around any of the following problems which apply to you :

Sexual Problems	Depression	Fears	Finances
Abuse	Divorce	Friends	Alcohol Use
Drug Use	Self-Control	Unhappiness	Sleep
Anger	Home Life	Work or Job	School
Stress	Headaches	Tiredness	Legal Matters
Relaxation	Ambition	Energy	Insomnia
Memory	Loneliness	Education	Perfectionist
Making Decisions	Performance	Separation	Eating Disorder
Concentration	Marriage	Children	Appetite
Nightmares	Attendance	Failed UA	Shyness
Stomach Trouble	Low Self-Esteem	Step-Children	Ex-Spouse
In-Laws	Phobia(s)	Confusion	Binge Eating
Anxiety	Over-Commitment	Gender Identity	Aging
Suicidal Thoughts	Health Problems	Strange Thoughts	

Of the problems circled or mentioned above, which do you consider most severe at the present time?

_____

_____

Other information which you think might be helpful in our work with you:_____

_____

Please give 24 hour notice if you cannot keep your appointment