



# LIFE MANAGEMENT ASSOCIATES, LLC

## NEW CLIENT QUESTIONNAIRE

**INSTRUCTIONS:** Please answer these questions to help assist us in understanding the client's needs and concerns. If you need additional space to answer any question, please feel free to add additional sheets of paper. If you retain any documents concerning prior treatment, testing, reports, etc. please attach those to this new client questionnaire. When we agree to treat a couple or a family, we consider that couple or family to be the client. We would like each individual included in individual, and couple therapy to complete this form prior to the intake appointment, so that the therapist has background information on all participants. For the purpose of family therapy, we may require new client questionnaires on each individual family member.

### Sources of Data Provided Below

☐ Client self-report for all ☐ Client's parent/guardian ☐ A variety of sources: \_\_\_\_\_

Please check the category below that best matches the client's treatment request.

- |  |   |
|--|---|
| <input type="checkbox"/> Individual Adult Issues | <input type="checkbox"/> Mental Health Evaluation             |
| <input type="checkbox"/> Child/Adolescent Issues | <input type="checkbox"/> Substance Abuse/Addiction Evaluation |
| <input type="checkbox"/> Couple/Marriage Issues  | <input type="checkbox"/> GAL, Guardian Ad Litem Services      |
| <input type="checkbox"/> Family Issues           |   |

### CLIENT INFORMATION

Client Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #s (Hm) (\_\_\_\_) \_\_\_\_\_ (Wk) (\_\_\_\_) \_\_\_\_\_ (Cell) (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Ethnicity: ☐ Asian ☐ African-American ☐ Native American ☐ White/Caucasian ☐ Other, specify \_\_\_\_\_

Marital Status: ☐ Single - Never Married ☐ Engaged ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Live in Partner

Sex: F ☐ M ☐ Who was the client referred by? \_\_\_\_\_

**EMERGENCY CONTACT:** Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Release Signed? Yes: ☐ No: ☐ , if other than parent/legal guardian.

Cell #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Relationship: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ specify \_\_\_\_\_

600 Dewey Blvd., Suite B • Butte, MT 59701 • 302 Missouri Ave., Deer Lodge, MT 59722  
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## NEW CLIENT QUESTIONNAIRE

### Cultural/spiritual/religious history

Describe the client's cultural identity (e.g., religion, nationality, family traditions, etc.)

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Describe any cultural/spiritual/religious issues that contribute to current problem and/or should be taken into account during treatment

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- ☐ currently active in community/recreational activities?
- ☐ formerly active in community/recreational activities?
- ☐ currently engage in hobbies?
- ☐ currently participate in spiritual activities?

If answered "yes" to any of above, describe

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### PARTNER OR PARENT/LEGAL GUARDIAN INFORMATION

If minor is in state custody, the state representative must complete the appropriate questions within this section.

Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #s (Hm) (\_\_\_\_) \_\_\_\_\_ (Wk) (\_\_\_\_) \_\_\_\_\_ (Cell) (\_\_\_\_) \_\_\_\_\_

Marital Status, ☐ Single– Never Married ☐ Engaged ☐ Married ☐ Divorced ☐ Separated ☐ Live in Partner ☐ Widowed

Sex: F ☐ M ☐ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ specify \_\_\_\_\_

### OTHER PARTICIPATING FAMILY MEMBERS (List Names and Age)

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# LIFE MANAGEMENT ASSOCIATES, LLC

## NEW CLIENT QUESTIONNAIRE

### Presenting Problems

Primary

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Secondary

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### Current Symptom Checklist (Rate intensity of symptoms currently present)

**Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning

**Moderate** = Significant impact on quality of life and/or day-to-day functioning

**Severe** = Profound impact on quality of life and/or day-to-day functioning

| <u>Symptom</u>                | <u>Impact</u>            |                          |                          |                          | <u>Symptom</u>               | <u>Impact</u>            |                          |                          |                          |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                               | None                     | Mild                     | Moderate                 | Severe                   |                              | None                     | Mild                     | Moderate                 | Severe                   |
| Aggressive Behaviors          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laxative/Diuretic Abuse      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Agitation                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loose Associations           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anorexia                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mood Swings                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Appetite Disturbance          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Obsessions/Compulsions       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bingeing/Purging              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Oppositional Behavior        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Circumstantial Symptoms       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Panic Attacks                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Concomitant Medical Condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Paranoid Ideation            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Conduct Problems              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Phobias                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Delusions                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Physical Trauma Perpetrator  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Depressed Mood                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Physical Trauma Victim       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dissociative States           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor Concentration           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Elevated Mood                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor Grooming                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Elimination Disturbance       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Psychomotor Retardation      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Emotional Trauma Perpetrator  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Self-Mutilation              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Emotional Trauma Victim       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexual Dysfunction           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Emotionality                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexual Trauma Perpetrator    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue/Low Energy            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexual Trauma Victim         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Generalized Anxiety           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Significant Weight Gain/Loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Grief                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Disturbance            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Guilt                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Social Isolation             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hallucinations                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Somatic Complaints           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hopelessness                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Substance Abuse              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hyperactivity                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Worthlessness                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Irritability                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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## NEW CLIENT QUESTIONNAIRE

Explanation onset, duration and frequency for any of the symptoms that you have listed above:

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### Client Emotional/Psychiatric History

☐ ☐ Client, Prior outpatient psychotherapy?

No Yes If yes, on \_\_\_\_ occasions. Longest treatment by \_\_\_\_\_ for \_\_\_\_ sessions from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Provider Name Month/Year Month/Year

| <u>Prior provider name</u> | <u>City</u> | <u>State</u> | <u>Diagnosis</u> | <u>Intervention/Modality</u> | <u>Beneficial?</u> |
|----------------------------|-------------|--------------|------------------|------------------------------|--------------------|
|----------------------------|-------------|--------------|------------------|------------------------------|--------------------|

|       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

☐ ☐ Client, Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?

No Yes If yes, on \_\_\_\_ occasions. Longest treatment at \_\_\_\_\_ from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name of facility Month/Year Month/Year

| <u>Inpatient facility name</u> | <u>City</u> | <u>State</u> | <u>Diagnosis</u> | <u>Intervention/Modality</u> | <u>Beneficial?</u> |
|--------------------------------|-------------|--------------|------------------|------------------------------|--------------------|
|--------------------------------|-------------|--------------|------------------|------------------------------|--------------------|

|       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

☐ ☐ Has the client had suicidal ideation and/or attempts? If yes, explain suicidal ideation and/or attempts

No Yes

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# LIFE MANAGEMENT ASSOCIATES, LLC

## NEW CLIENT QUESTIONNAIRE

☐ ☐ **Has the client experienced a traumatic event?**

No Yes

If yes, the traumatic event occurred on \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month/Year

Please describe what occurred during the traumatic event \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ ☐ **Has the client been previously treated for the traumatic event?**

No Yes

If yes, on \_\_\_\_ occasions. Longest treatment by \_\_\_\_\_ from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name of Provider Month/Year Month/Year

## Family Emotional/Psychiatric/Substance Abuse History

☐ ☐ **Does any family member have a history of mental illness and or substance abuse? If yes, list all**

No Yes

Name and relationship to client

Diagnosis

Treatment (e.g., outpatient psychotherapy, inpatient, medication, none)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Family alcohol/drug abuse history

- |   |   |
|---|---|
| <input type="checkbox"/> father         | <input type="checkbox"/> stepparent/live-in       |
| <input type="checkbox"/> mother         | <input type="checkbox"/> uncle(s)/aunt(s)         |
| <input type="checkbox"/> grandparent(s) | <input type="checkbox"/> spouse/significant other |
| <input type="checkbox"/> sibling(s)     | <input type="checkbox"/> children                 |
| <input type="checkbox"/> other _____    |   |

**Any other relevant family emotional/psychiatric/substance abuse information, please explain:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# LIFE MANAGEMENT ASSOCIATES, LLC

## NEW CLIENT QUESTIONNAIRE

### Medical History (check all that apply for client)

Describe the client's current physical health ☐ Good ☐ Fair ☐ Poor

description if relevant: \_\_\_\_\_

### List name of primary care physician for the client

Name \_\_\_\_\_ Phone \_\_\_\_\_

### List name of psychiatrist for the client (if any):

Name \_\_\_\_\_ Phone \_\_\_\_\_

### Is there a history of any of the following in the family

- |   |   |
|---|---|
| <input type="checkbox"/> tuberculosis                                   | <input type="checkbox"/> heart disease                |
| <input type="checkbox"/> birth defects                                  | <input type="checkbox"/> high blood pressure          |
| <input type="checkbox"/> emotional problems                             | <input type="checkbox"/> alcoholism                   |
| <input type="checkbox"/> behavior problems                              | <input type="checkbox"/> drug abuse                   |
| <input type="checkbox"/> thyroid problems                               | <input type="checkbox"/> diabetes                     |
| <input type="checkbox"/> cancer   | <input type="checkbox"/> Alzheimer's disease/dementia |
| <input type="checkbox"/> mental retardation                             | <input type="checkbox"/> stroke                       |
| <input type="checkbox"/> other chronic or serious health problems _____ |   |

### List any known allergies for the client

### Describe any serious hospitalization or accidents for the client

Year Age Reason

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

### List any abnormal lab test results for the client

Year Result

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |



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## NEW CLIENT QUESTIONNAIRE

### Clients Sexual history

- ☐ heterosexual orientation
- ☐ homosexual orientation
- ☐ bisexual orientation
- ☐ transgender
- ☐ other \_\_\_\_\_
- ☐ currently sexually active
- ☐ currently sexually satisfied
- ☐ currently sexually dissatisfied

age first sex experience \_\_\_\_\_

age first pregnancy/fatherhood \_\_\_\_\_

history of promiscuity age \_\_\_\_\_ to \_\_\_\_\_

history of unsafe sex age \_\_\_\_\_ to \_\_\_\_\_

Any additional information pertaining  
to the clients sexual history, including  
abuse, assault or perpetrating

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### **Client Mental Health and Other Prescribed Medications**

☐ ☐ Prior or current mental health medication usage? If yes, list below

No Yes

| <u>Medication</u> | <u>Dosage</u> | <u>Frequency</u> | <u>Start Date</u> | <u>End Date</u> | <u>Physician</u> |
|-------------------|---------------|------------------|-------------------|-----------------|------------------|
| _____             | _____         | _____            | _____             | _____           | _____            |
| _____             | _____         | _____            | _____             | _____           | _____            |
| _____             | _____         | _____            | _____             | _____           | _____            |

List any other medications currently being taken (give reason, including other prescribed medication and over-the-counter)

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Please provide any other relevant information, or adverse side effects concerning the use of medications:

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# LIFE MANAGEMENT ASSOCIATES, LLC

## NEW CLIENT QUESTIONNAIRE

### Substance Use History (check all that apply for client)

#### Client Substance use status

- ☐ no history of abuse
- ☐ active abuse
- ☐ early full remission
- ☐ early partial remission
- ☐ sustained full remission
- ☐ sustained partial remission

#### Client Treatment history

- ☐ Outpatient (age[s]) \_\_\_\_\_
- ☐ Inpatient (age[s]) \_\_\_\_\_
- ☐ 12-step program (age[s]) \_\_\_\_\_
- ☐ stopped on own (age[s]) \_\_\_\_\_
- ☐ other (age[s]) \_\_\_\_\_

#### Client Substances used

- ☐ alcohol
- ☐ amphetamines/speed
- ☐ barbiturates/owners
- ☐ cocaine
- ☐ crack cocaine
- ☐ hallucinogens (e.g., LSD)
- ☐ inhalants (e.g., glue, gas)
- ☐ marijuana or hashish
- ☐ opioids
- ☐ PCP
- ☐ prescription
- ☐ other

#### First use age

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Last use age

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_

#### Current Use

- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

#### Frequency

\_\_\_\_\_  
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#### Amount

\_\_\_\_\_  
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\_\_\_\_\_

#### Consequences of substance abuse

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> hangovers           | <input type="checkbox"/> medical conditions               | <input type="checkbox"/> suicide attempts          |
| <input type="checkbox"/> seizures            | <input type="checkbox"/> Increase in tolerance            | <input type="checkbox"/> suicidal impulse/thoughts |
| <input type="checkbox"/> blackouts           | <input type="checkbox"/> loss of control over amount used | <input type="checkbox"/> relationship conflicts    |
| <input type="checkbox"/> Accidental overdose | <input type="checkbox"/> job loss                         | <input type="checkbox"/> arrests                   |
| <input type="checkbox"/> binges              | <input type="checkbox"/> sleep disturbance                |  |
| <input type="checkbox"/> withdrawal symptoms | <input type="checkbox"/> assaults                         |  |
| <input type="checkbox"/> other _____         |   |  |





# LIFE MANAGEMENT ASSOCIATES, LLC

## NEW CLIENT QUESTIONNAIRE

### Client Family History

#### Client Family of Origin

##### Present during childhood

|            | Present<br>entire<br>childhood | Present<br>part of<br>childhood | Not Present<br>at all    |
|------------|--------------------------------|---------------------------------|--------------------------|
| mother     | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |
| father     | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |
| stepmother | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |
| stepfather | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |
| brother(s) | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |
| sister(s)  | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |
| other      | <input type="checkbox"/>       | <input type="checkbox"/>        | <input type="checkbox"/> |

##### Client's Parents' current marital status

- ☐ married to each other
- ☐ separated for \_\_\_\_ years
- ☐ divorced for \_\_\_\_ years
- ☐ mother remarried \_\_\_\_ times
- ☐ father remarried \_\_\_\_ times
- ☐ mother involved with someone
- ☐ father involved with someone
- ☐ mother deceased for \_\_\_\_ years  
age of client at mother's death \_\_\_\_
- ☐ father deceased for \_\_\_\_ years  
age of client at father's death \_\_\_\_

##### Describe childhood family experience for the client

- ☐ outstanding home environment
- ☐ normal home environment
- ☐ chaotic home environment
- ☐ witnessed physical/verbal/sexual abuse toward others
- ☐ experienced physical/verbal/sexual abuse from others

Client age of emancipation from home: \_\_\_\_\_, reason: \_\_\_\_\_

Client special circumstances in childhood [anything you believe is relevant about your childhood history]

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# LIFE MANAGEMENT ASSOCIATES, LLC

## NEW CLIENT QUESTIONNAIRE

### Client Immediate Family

#### Client marital status

- ☐ single, never married
- ☐ engaged \_\_\_\_\_ months
- ☐ married for \_\_\_\_\_ years
- ☐ divorced for \_\_\_\_\_ years
- ☐ separated for \_\_\_\_\_ years
- ☐ divorce in process \_\_\_\_\_ months
- ☐ spouse/partner deceased for \_\_\_\_\_ years
- ☐ live-in for \_\_\_\_\_ years
- ☐ \_\_\_\_\_ prior marriages (self)
- ☐ \_\_\_\_\_ prior marriages (partner)

#### Client relationship satisfaction

- ☐ very satisfied with relationship
- ☐ satisfied with relationship
- ☐ somewhat satisfied with relationship
- ☐ dissatisfied with relationship
- ☐ very dissatisfied with relationship

### List all persons currently living in client's household

| <u>Name</u> | <u>Age</u> | <u>Sex</u> | <u>Relationship to Client</u> |
|-------------|------------|------------|-------------------------------|
| _____       | _____      | _____      | _____                         |
| _____       | _____      | _____      | _____                         |
| _____       | _____      | _____      | _____                         |
| _____       | _____      | _____      | _____                         |

### List biological/adopted children not living in same household as patient

| <u>Name</u> | <u>Age</u> | <u>Sex</u> | <u>Relationship to Client</u> |
|-------------|------------|------------|-------------------------------|
| _____       | _____      | _____      | _____                         |
| _____       | _____      | _____      | _____                         |
| _____       | _____      | _____      | _____                         |
| _____       | _____      | _____      | _____                         |

Describe any past or current significant issues in intimate relationships, the client may have: \_\_\_\_\_

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# LIFE MANAGEMENT ASSOCIATES, LLC

## NEW CLIENT QUESTIONNAIRE

### Client Socio-Economic History (check all that apply)

#### Living situation

- ☐ housing adequate
- ☐ homeless
- ☐ housing overcrowded
- ☐ dependent on others for housing
- ☐ housing dangerous/deteriorating
- ☐ living companions dysfunctional

#### Social support system

- ☐ supportive network
- ☐ few friends
- ☐ substance-use-based friends
- ☐ no friends
- ☐ distant from family of origin

#### Military

- ☐ never in military
- ☐ served in military - no incident
- ☐ served in military - with incident

### Client Developmental History (check all that apply for the client)

#### Client problems during mother's pregnancy

- ☐ none
- ☐ high blood pressure
- ☐ kidney infection
- ☐ German measles
- ☐ emotional stress
- ☐ bleeding
- ☐ alcohol use
- ☐ drug use
- ☐ cigarette use
- ☐ other

#### Client birth

- ☐ normal delivery
  - ☐ difficult delivery
  - ☐ cesarean delivery
  - ☐ complications
- \_\_\_\_\_
- \_\_\_\_\_

#### Client infancy problems

- ☐ none
- ☐ feeding problems
- ☐ sleep problems
- ☐ toilet training problems

birth weight \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

#### Client delayed developmental milestones (check only those milestones that did not occur at expected age):

- |  |  |
|--|--|
| <input type="checkbox"/> sitting             | <input type="checkbox"/> controlling bowels    |
| <input type="checkbox"/> rolling over        | <input type="checkbox"/> sleeping alone        |
| <input type="checkbox"/> standing            | <input type="checkbox"/> dressing self         |
| <input type="checkbox"/> walking             | <input type="checkbox"/> engaging peers        |
| <input type="checkbox"/> feeding self        | <input type="checkbox"/> tolerating separation |
| <input type="checkbox"/> speaking words      | <input type="checkbox"/> playing cooperatively |
| <input type="checkbox"/> speaking sentences  | <input type="checkbox"/> riding tricycle       |
| <input type="checkbox"/> controlling bladder | <input type="checkbox"/> riding bicycle        |
| <input type="checkbox"/> other _____         |  |



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## NEW CLIENT QUESTIONNAIRE

### Client emotional / behavior problems during childhood (check all that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> none            | <input type="checkbox"/> repeats words of others | <input type="checkbox"/> distrustful                               |
| <input type="checkbox"/> drug use        | <input type="checkbox"/> not trustworthy         | <input type="checkbox"/> extreme worrier                           |
| <input type="checkbox"/> alcohol abuse   | <input type="checkbox"/> hostile/angry mood      | <input type="checkbox"/> self-injurious acts                       |
| <input type="checkbox"/> chronic lying   | <input type="checkbox"/> indecisive              | <input type="checkbox"/> impulsive                                 |
| <input type="checkbox"/> stealing        | <input type="checkbox"/> immature                | <input type="checkbox"/> easily distracted                         |
| <input type="checkbox"/> violent temper  | <input type="checkbox"/> bizarre behavior        | <input type="checkbox"/> poor concentration                        |
| <input type="checkbox"/> fire-setting    | <input type="checkbox"/> self-injurious threats  | <input type="checkbox"/> often sad                                 |
| <input type="checkbox"/> hyperactive     | <input type="checkbox"/> frequently tearful      | <input type="checkbox"/> breaks things in anger                    |
| <input type="checkbox"/> animal cruelty  | <input type="checkbox"/> lack of attachment      | <input type="checkbox"/> Withdraws/avoids interactions with others |
| <input type="checkbox"/> assaults others |  |  |
| <input type="checkbox"/> disobedient     |  |  |
| <input type="checkbox"/> other _____     |  |  |

### Client social interaction during childhood (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> normal social interaction | <input type="checkbox"/> inappropriate sex play           |
| <input type="checkbox"/> isolates self             | <input type="checkbox"/> dominates others                 |
| <input type="checkbox"/> very shy                  | <input type="checkbox"/> associates with acting-out peers |
| <input type="checkbox"/> alienates self            |   |
| <input type="checkbox"/> other _____               |   |

### Client intellectual / academic functioning

- |  |   |
|--|---|
| <input type="checkbox"/> normal intelligence | <input type="checkbox"/> underachieving       |
| <input type="checkbox"/> high intelligence   | <input type="checkbox"/> mild retardation     |
| <input type="checkbox"/> learning problems   | <input type="checkbox"/> moderate retardation |
| <input type="checkbox"/> authority conflicts | <input type="checkbox"/> severe retardation   |
| <input type="checkbox"/> attention problems  |   |

Client's current or highest education level \_\_\_\_\_

Describe any other developmental [physical, emotional, behavioral, social, intellectual or academic] problems or issues, the client may have had during childhood.

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# LIFE MANAGEMENT ASSOCIATES, LLC

## NEW CLIENT QUESTIONNAIRE

### Client Employment

- ☐ employed and satisfied
- ☐ employed but dissatisfied
- ☐ Employed full time
- ☐ Employed part time
- ☐ Disabled:

\_\_\_\_\_

### Current Occupation

\_\_\_\_\_

### Current Employer

\_\_\_\_\_

### Location

\_\_\_\_\_

### Client Financial Situation

- ☐ no current financial problems
- ☐ large indebtedness
- ☐ poverty or below-poverty income
- ☐ impulsive spending
- ☐ relationship conflicts over finances

- ☐ Coworker conflicts
- ☐ Supervisor conflicts
- ☐ Unstable work history

### Client Legal History

- ☐ no legal problems
- ☐ now on parole/probation
- ☐ arrest(s) not substance-related
- ☐ arrest(s) substance-related
- ☐ court ordered this treatment
- ☐ jail/prison \_\_\_\_\_ time(s)
- total time served: \_\_\_\_\_

### Describe Any Client Legal Difficulties

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# LIFE MANAGEMENT ASSOCIATES, LLC

## NEW CLIENT QUESTIONNAIRE

**Strengths:** The client exhibits the following strengths, check all that apply?

- |  |  |
|--|--|
| <input type="checkbox"/> Accepts Guidance/Feedback | <input type="checkbox"/> Motivated for Change      |
| <input type="checkbox"/> Calm                      | <input type="checkbox"/> Physically Healthy        |
| <input type="checkbox"/> Capable of Independence   | <input type="checkbox"/> Positive Support Network  |
| <input type="checkbox"/> Clear Thinking            | <input type="checkbox"/> Reasonable Judgment       |
| <input type="checkbox"/> Confident                 | <input type="checkbox"/> Reliable                  |
| <input type="checkbox"/> Cooperative               | <input type="checkbox"/> Responsible               |
| <input type="checkbox"/> Expressive/Articulate     | <input type="checkbox"/> Sociable                  |
| <input type="checkbox"/> Good Personal Care Habits | <input type="checkbox"/> Stable Living Environment |
| <input type="checkbox"/> Insightful                | <input type="checkbox"/> Stable Work History       |
| <input type="checkbox"/> Integrated Moral Values   | <input type="checkbox"/> Supportive Family         |
| <input type="checkbox"/> Intelligent               | <input type="checkbox"/> Varied Interests          |

Other *explain*: \_\_\_\_\_

**Limitations:** The client exhibits the following limitations, check all that apply?

- |  |  |
|--|--|
| <input type="checkbox"/> Aggressive            | <input type="checkbox"/> Lacks Moral/Ethical Values  |
| <input type="checkbox"/> Chaotic Living        | <input type="checkbox"/> Lacks Social Skills         |
| <input type="checkbox"/> Concrete Thinking     | <input type="checkbox"/> Needs Close Supervision     |
| <input type="checkbox"/> Defensive             | <input type="checkbox"/> Negative Peer Group         |
| <input type="checkbox"/> Demanding             | <input type="checkbox"/> No Support Network          |
| <input type="checkbox"/> Dependent             | <input type="checkbox"/> Non-Supportive Family       |
| <input type="checkbox"/> Distrustful           | <input type="checkbox"/> Not Motivated to Change     |
| <input type="checkbox"/> Easily Distracted     | <input type="checkbox"/> Not Open/Articulate         |
| <input type="checkbox"/> Hostile               | <input type="checkbox"/> Poor Health                 |
| <input type="checkbox"/> Illiterate            | <input type="checkbox"/> Poor Hygiene/Grooming       |
| <input type="checkbox"/> Impulsive             | <input type="checkbox"/> Poor Judgment               |
| <input type="checkbox"/> Indecisive            | <input type="checkbox"/> Unreliable                  |
| <input type="checkbox"/> Intellectual Deficits | <input type="checkbox"/> Unstable Employment History |
| <input type="checkbox"/> Irresponsible         | <input type="checkbox"/> Very Narrow Interests       |
| <input type="checkbox"/> Lacks Insight         |  |

Other *explain*: \_\_\_\_\_



# LIFE MANAGEMENT ASSOCIATES, LLC

## NEW CLIENT QUESTIONNAIRE

Does the client have any additional issues or concerns not previously identified by any of the prior questions?

*If so, please explain below:*

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# LIFE MANAGEMENT ASSOCIATES, LLC

## NEW CLIENT QUESTIONNAIRE

**Confidentiality of E-mail, Voice Mail, and Fax Communication:** E-mail, voice mail, and fax communication can be accessed by unauthorized people, compromising the privacy and confidentiality of such communication. LMA cannot guarantee confidentiality of e-mail, voice mail, and fax communication. If you choose to communicate confidential information with LMA via e-mail, voice mail, and fax communication, LMA will assume that you have made an informed decision and LMA will view it as your agreement to take the risk that e-mail, voice mail, and fax communication may be intercepted.

Understanding the above information, please indicate your communication preferences.

|                  |  |  |  |
|------------------|--|--|--|
| OK to send mail? | Yes <input type="checkbox"/> No <input type="checkbox"/> | OK to send email?                      | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| OK to call cell? | Yes <input type="checkbox"/> No <input type="checkbox"/> | OK to leave voicemail message on cell? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| OK to call home? | Yes <input type="checkbox"/> No <input type="checkbox"/> | OK to leave voicemail message at home? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| OK to call work? | Yes <input type="checkbox"/> No <input type="checkbox"/> | OK to leave voicemail message at work? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| OK to text cell? | Yes <input type="checkbox"/> No <input type="checkbox"/> |  |  |

### CONSENT TO THE FOLLOWING SERVICES

*The client/parent/legal guardian requests and consents to the following services:*

- ☐ Mental Health Evaluation, Interpretation Of Results, & Preparation Of Reports
- ☐ Counseling/Psychotherapy (Individual, Couples, Family, Or Group)
- ☐ Family Systems Evaluation, Interpretation Of Results, & Preparation Of Reports
- ☐ Substance Abuse/Addiction Evaluation And Interpretation Of Results
- ☐ GAL, Guardian Ad Litem Services
- ☐ Other services: \_\_\_\_\_

I attest that the information provided in or attached to this questionnaire is complete, accurate, and true to the best of my knowledge.

\_\_\_\_\_  
Client Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature [mandatory if client is a minor]

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Therapist/Representative of Life Management Associates, LLC

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

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