

SONYA L. FONTAINE LPC, PLLC

CLIENT INFORMATION QUESTIONNAIRE

Page 1 of 4

Date: _____

CLIENT INFORMATION

Name (first, middle initial, last): _____

Sex: ☐ Male ☐ Female

Age: _____ Date of birth: _____

Street address: _____ Apt. #: _____

City: _____ State: _____ ZIP: _____

Work phone: _____ Cell phone: _____

Email: _____

Permission to contact by email: ☐ Yes ☐ No

Permission to contact at work: ☐ Yes ☐ No

Permission to leave a message on your cell phone: ☐ Yes ☐ No

Marital status: ☐ Single ☐ Married ☐ Remarried ☐ Separated

☐ Divorced Date / how long: _____ ☐ Widowed Date / how long: _____

Employer: _____ Occupation: _____

Employer phone: _____ Employer address: _____

Employer city: _____ State: _____ ZIP: _____

Education: ☐ Grade school ☐ High school ☐ Technical degree

☐ Bachelor's degree ☐ Master's degree ☐ Advanced degree

Do you attend church? ☐ Yes ☐ No

Church attended: _____ How regularly: _____

Church member: ☐ Yes ☐ No

SPOUSE INFORMATION (IF APPLICABLE)

Name (first, middle initial, last): _____

Sex: ☐ Male ☐ Female

Age: _____ Date of birth: _____

Employer: _____ Occupation: _____

Spouse phone: _____

Permission to contact spouse for scheduling: ☐ Yes ☐ No

Education: ☐ Grade school ☐ High school ☐ Technical degree

☐ Bachelor's degree ☐ Master's degree ☐ Advanced degree

Does your spouse attend church? ☐ Yes ☐ No

Church attended: _____ How regularly: _____

Church member: ☐ Yes ☐ No

FAMILY AND REFERRAL INFORMATION

Number of marriages - You: _____ Spouse: _____

Years married: _____

Child's name	Age	Child's name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Referral - Friend: _____ Physician: _____

Minister/church: _____ Other: _____

HEALTH INFORMATION

Primary care physician: _____ Phone: _____

Last visit: _____

Current medications and the reason for taking each:

Surgeries or major illnesses:

CURRENT CONCERNS AND HISTORY

Mark Current and/or Past. For past concerns, enter the date or approximate year.

DEPRESSION SYMPTOMS				ANXIETY SYMPTOMS				OTHER CONCERNS / HISTORY			
Concern	Current	Past	Date	Concern	Current	Past	Date	Concern	Current	Past	Date
Depression / sadness	☐	☐	_____	Anxiety / persistent worry	☐	☐	_____	Loss of a parent	☐	☐	_____
Loss of interest	☐	☐	_____	Obsessive thinking	☐	☐	_____	Loss of a spouse	☐	☐	_____
Loss of pleasure in activities	☐	☐	_____	Obsessive behaviors	☐	☐	_____	Loss of a child	☐	☐	_____
Loss of motivation	☐	☐	_____	Agitation / irritability	☐	☐	_____	Domestic abuse	☐	☐	_____
Change in sleep	☐	☐	_____	Social isolation	☐	☐	_____	Sexual abuse	☐	☐	_____
Change in appetite	☐	☐	_____	Panic attacks	☐	☐	_____	Physical abuse	☐	☐	_____
Change in energy level	☐	☐	_____					Divorce as a child Age: _____	☐	☐	_____
Frequent crying	☐	☐	_____					Divorce of spouse When: _____	☐	☐	_____
								Addiction Type: _____	☐	☐	_____
								Pornography concerns	☐	☐	_____
								Eating disorder	☐	☐	_____

Suicidal thoughts: ☐ No ☐ Yes ☐ Current ☐ Past

Frequency: _____ When: _____

Self-harm: ☐ No ☐ Yes ☐ Current ☐ Past

Frequency: _____ When: _____

Suicide attempt - Date: _____

Hospitalized? ☐ Yes ☐ No

Previously consulted a counselor or psychiatrist? ☐ Yes ☐ No

Date	Problem addressed	Counselor
_____	_____	_____
_____	_____	_____

REASONS FOR THERAPY AND GOALS

Briefly describe your reason for seeking therapy:

What have you tried to address this problem? What has and has not worked?

How will you know when therapy has been successful?

Please provide any additional information you feel is pertinent to therapy:

Would you like Sonya to pray with you in session? ☐ Yes ☐ No

Our goal is to best meet your emotional needs in a confidential, respectful and God-centered way. Please feel free to discuss this or any other issue with us.