Central Minnesota Mental Health Center
Client Questionnaire

Today's Date:_____

Identifying Information

Name: _____ Age: _____

Identity Considerations

Race / Culture: _____

Gender: _____

Pronouns: _____

Sexual Orientation: _____

Spirituality / Religion: _____

I would like things regarding my identity integrated into therapy. ◯ No ◯ Yes

Family

Please indicate your relationship status:

☐ Single ☐ Divorced
☐ Married ☐ Separated
☐ Widowed ☐ In a committed relationship

Please indicate your living arrangement at this time:

☐ I live alone ☐ With my spouse/significant other
☐ With family members ☐ In a board and lodge, foster home, or group home
☐ I am homeless

Pets _____

Please identify any children, their ages, and custody considerations:

_____

Mental Health History

Current Psychiatrist: _____

Clinic:_____ Last Seen: _____

Past Psychiatrist/Therapist: _____

Clinic:_____ Last Seen: _____

I have been hospitalized for mental health reasons: ◯ No ◯ Yes

If yes, when? Where? How many times?

_____

I am currently receiving mental health services: ◯ No ◯ Yes

If yes, what services?

_____

Trauma History

As a child or an adult:

- ◯ **YES** or ◯ **NO** – I have been physically assaulted or my life has been threatened.
- ◯ **YES** or ◯ **NO** – Someone has done unwanted sexual things with me or to me.
- ◯ **YES** or ◯ **NO** – I have experienced ongoing name calling, belittling, or emotional abuse.
- ◯ **YES** or ◯ **NO** – I have experienced or witnessed a serious accident, injury, death or violence thataffects me.

Substance Use History

CAGE-AID Substance Abuse Screening

- ◯ **YES** or ◯ **NO** – Have you felt you ought to cut down on your drinking or drug use?
- ◯ **YES** or ◯ **NO** – Have people annoyed you by criticizing your drinking or drug use?
- ◯ **YES** or ◯ **NO** – Do you feel bad or guilty about your drinking or drug use?
- ◯ **YES** or ◯ **NO** – Have you ever had a drink or used drugs first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started?

Chemical Use:

	Everyday Use	Occasional	Former Use	Never Used
Alcohol				
Marijuana				
Inhalants				
Opioids				
PCP/LSD/Acid/Mushroom				
Cocaine/Meth/Ecstasy				
Nicotine (tobacco/vaping)				
Caffeine				
Sedative/Hypnotic				
Abuse of Over the Counter				

◯ **YES** or ◯ **NO –** I have been or am in chemical dependency treatment.

If yes: Dates: _____ Place: _____ Number of times:____

How important is it to you to stop using tobacco?

Not at all Important **Extremely Important**

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐n/a

Would you like information about cutting down on tobacco use? ◯ **YES** or ◯ **NO**

Do you, or others, have concerns about any of the following:

☐ Gambling ☐ Computer/Internet, Screen Use ☐ Sexual Activity

☐ Pornography ☐ Other _____

Medical History

◯ **YES** or ◯ **NO** – I have a regular doctor that I see for physicals and when I get sick. Primary Care Provider (doctor): _____

Clinic: _____ Last Appointment: _____

Please list any medical conditions for which you have been treated and/or any surgeries.

_____

Medications, vitamins, or supplements you are currently taking (name and dosage).

_____

_____

◯ **YES** or ◯ **NO** – Are you allergic to: Drugs / Medications / Foods / Environment?

Please list your allergies and reactions: _____

Please list any physical disabilities: _____

_____

Please list any family history of health concerns (mental health, medical, substance use):

_____

_____

_____

◯ **YES** or ◯ **NO** – I have a dentist I see regularly.

◯ **YES** or ◯ **NO** – I attend occupational therapy.

Developmental History

Please check if you have dealt with any of the following issues during childhood or adolescence.

☐ Birth History/Complications ☐ Connecting with Caregiver

☐ Special Education ☐ Repeated a school year

☐ Learning Disabilities ☐ Hearing/Vision problems

☐ Speech therapy ☐ Sensory limitations

☐ Orthopedic problems ☐ Wetting/Soiling

☐ Developmental delays (crawling, walking, first words, toilet training, socializing) ☐ Other developmental concerns

Basic Needs

Are you able to meet your needs in the following areas?

◯ **YES or** ◯ **NO** – Housing ◯ **YES or** ◯ **NO** – Clothing

◯ **YES or** ◯ **NO** – Nutrition ◯ **YES or** ◯ **NO** – Income

Education

Years/Level of Education:_____

◯ **YES** or ◯ **NO** – Did you receive a diploma or GED?

Comment about and/or circle any problems you may have had in school (behavior, grades, truancy, suspension, expulsion, fighting, problems with peers, or problems with authority):

_____

_____

_____

Employment

◯ **YES** or ◯ **NO** – Are you currently employed? If yes:

Employer:_____ Job title:_____

Length of time on job:_____ Hours per week:_____

YES or **NO** – Have you served in the military? If yes:

Branch: _____ Dates: _____

Legal Considerations

Please list or describe any current/pending legal issues:_____

Name(s) of Probation Officer/CPS Worker:_____Release signed: ◯ **YES** or ◯ **NO**

List any past legal problems involving charges, jail/prison time, court orders, child protection, or civil commitments:_____

Satisfaction

How satisfied are you in the following areas:

	Very Satisfied	Satisfied	Neutral	Dis-satisfied	Very Dissatisfied	NA/Other
Employment	☐	☐	☐	☐	☐	☐
Social Network	☐	☐	☐	☐	☐	☐

Intimate Relationship						
Family Relationship						

What else would you like to share with your therapist?_____

_____

_____