Clinical Interview Questionnaire

Personal Information

Today's date: _____

Client's full name: _____

Date of birth: _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

Job title: _____

Please indicate the **PRIMARY** problem that has led you to seek help today.
__ Sad or depressed mood
__ Problems with friends
__ Physical health problems
__ Anxiety, worries, or fears
__ Work problems
__ Family problems
__ Substance use
__ Other problems: _____

In the past 30 days, how much have your problems bothered you.

__ Not at all
__ A little
__ Somewhat
__ Quite a bit
__ Very much

How long have you had the problems for which you are seeking treatment?

__ Less than 1 month __ 1-3 months __ 4-6 months __ 7-12 months __ One or more years

Why have you decided to seek treatment/evaluation at this time?
_____

What have you done to this point to address these problems?
_____

What type of assistant do you hope to receive from this evaluation?
_____

Education History

Ever held back/repeated a grade? **Y / N**

If yes, what grade(s) and why?

Typically what grades did you make?

Were there dramatic changes in your grades? Please explain

_____

Were you suspended or expelled from school? Explain.

_____

Your Family

Married? **Y / N**

Spouse name: _____ Age: ____

Quality of relationship with you: _____

Mother Name: _____

Living?: _____ Age: _____

Quality of relationship with you: _____

Father Name: _____

Living?: _____ Age: _____

Quality of relationship with you: _____

Sister(s) Name: _____

Living?: _____ Age: _____

Quality of relationship with you: _____

Brother(s) Name: _____

Living?: _____ Age: _____

Quality of relationship with you: _____

Significant family mental health problems? _____

_____

Personal Health

Who is your physician? _____

Last visit: _____

Current medications (include dosage): _____

Medications prescribed in past 3 years: _____

List, beginning at birth, all diseases, illnesses, accidents and injuries, hospitalizations, seizures/convulsions, and other medical conditions that you have had: _____

_____

Any other concerns related to your health? _____

What types of physical activity do you do? _____

How much caffeine do you consume daily (cola, coffee, tea)? _____

Any dietary restrictions? _____

Average hours of sleep: _____

weekday: _____

weekend: _____

Problems sleeping? _____

Appetite problems? _____

Have you ever been evaluated for psychological, behavioral, or learning problems? **Y / N**

Do you recall who evaluated you, what type of evaluation it was, when it occurred, and what you were told? _____

Have you ever received psychiatric or psychological treatment? **Y / N**

What type of treatment did you receive and how long did it last? _____

Who provided this treatment? _____

Have you ever received any medication for your behavioral or emotional problems? **Y / N**

What type of medication, what dose, for how long? _____

	How often do you use	Quantity used
Alcohol:	_____	_____
Tobacco:	_____	_____
Marijuana:	_____	_____
Other drugs:	_____	_____

Do you feel guilty about your current or past use of substances? **Y / N**

Have you ever tried to cut down on your use? **Y / N**

Have friends or family members ever expressed concern? **Y / N**

Has your use ever interfered with your work or family roles? **Y / N**

Have you ever received inpatient/outpatient substance-abuse treatment? **Y / N**

When: _____

Where: _____

Have you ever participated in a 12-step program? YES NO

Which program(s) and when? _____

Problems at work?: _____

Other important information:

_____

_____

_____

_____

_____

_____

_____

_____