University of Colorado Denver
Student and Community Counseling Center

Client History Questionnaire
4/2011

Name: ______________________________

Date: ______________________________

The following questions are asked of all potential clients. Please answer to your comfort level. Your answers will help us best match services to your needs.

1. Over the last 2 weeks have you experienced any of the following?

		YES	NO	Prefer not to answer at this time
A.	Little interest or pleasure in doing things	YES	NO	NO ANSWER
B.	Feeling down, depressed, or hopeless	YES	NO	NO ANSWER
C.	Trouble falling or staying asleep, or sleeping too much	YES	NO	NO ANSWER
D.	Feeling tired or having little energy	YES	NO	NO ANSWER
E.	Poor appetite or overeating	YES	NO	NO ANSWER
F.	Feeling bad about yourself	YES	NO	NO ANSWER
G.	Trouble concentrating on things, such as reading the newspaper or watching TV	YES	NO	NO ANSWER
H.	Moving or speaking so slowly that other people have noticed a difference	YES	NO	NO ANSWER
I.	Being so fidgety or restless that you have been moving around a lot more than usual	YES	NO	NO ANSWER
J.	Feeling nervous, anxious, on edge or worrying a lot about different things	YES	NO	NO ANSWER
K.	Being easily annoyed or irritable	YES	NO	NO ANSWER

	YES	NO	Prefer not to answer at this time
2. In the last four weeks have you had an anxiety attack – suddenly feeling fear or panic?			

If NO, go to question 3, if YES please answer the questions below

		YES	NO	Prefer not to answer at this time
A.	Have you had a previous history of anxiety attacks	YES	NO	NO ANSWER
B.	Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable?	YES	NO	NO ANSWER
C.	Do these attacks bother you a lot or are you worried about having another attack	YES	NO	NO ANSWER
D.	Think about your last bad anxiety attack:	YES	NO	NO ANSWER
	1. Were you short of breath	YES	NO	NO ANSWER

2. Did your heart race, pound, skip	YES	NO	NO ANSWER
3. Did you have chest pain or pressure	YES	NO	NO ANSWER
4. Did you sweat	YES	NO	NO ANSWER
5. Did you feel as if you were choking	YES	NO	NO ANSWER
6. Did you have hot flashes or chills	YES	NO	NO ANSWER
7. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea	YES	NO	NO ANSWER
8. Did you feel dizzy, unsteady or faint	YES	NO	NO ANSWER
9. Did you have tingling or numbness in parts of your body	YES	NO	NO ANSWER
10. Did you tremble or shake	YES	NO	NO ANSWER
11. Were you afraid you were dying	YES	NO	NO ANSWER

3. Do you often have difficulty controlling or are particularly strict about what or how much you eat? **YES** **NO** **Prefer not to answer at this time**

If NO, go to question 4, if YES please answer the questions below

	YES	NO	Prefer not to answer at this time
A. Do you often eat, within any 2 hour period, what most people would regard as an unusually large amount of food	YES	NO	NO ANSWER
B. Do you or others around you perceive you to be unusually controlled regarding your food intake	YES	NO	NO ANSWER
C. In the last 3 months, have you often done any of the following in order to avoid gaining weight:			
1. Made yourself vomit	YES	NO	NO ANSWER
2. Took more than twice the recommended dose of laxatives	YES	NO	NO ANSWER
3. Fasted – not eaten anything at all for at least 24hrs	YES	NO	NO ANSWER
4. Exercised for more than an hour specifically to avoid gaining weight after eating an unusually large amount of food	YES	NO	NO ANSWER

4. Have you ever consumed alcohol? **YES** **NO** **Prefer not to answer at this time**

If NO, go to question 6, if YES please answer the questions below

	YES	NO	Prefer not to answer at this time

		YES	NO	NO ANSWER
A.	At any point, have you ever considered your alcohol use a problem	YES	NO	NO ANSWER
B.	Do you consider yourself to be in recovery	YES	NO	NO ANSWER

5. Do you currently consume alcohol? **YES** **NO** **Prefer not to answer at this time**

If NO, go to question 6, if YES please answer the questions below

		YES	NO	Prefer not to answer at this time
A.	Have any of the following happened to you more than once in the last 6 months:			
1.	You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health	YES	NO	NO ANSWER
2.	You drank alcohol, were drunk from alcohol, or hungover while you were working, going to school, or taking care of other responsibilities	YES	NO	NO ANSWER
3.	You missed or were late for work, school, or other activities because you were drinking or hungover	YES	NO	NO ANSWER
4.	You had a problem getting along with other people while you were drinking	YES	NO	NO ANSWER
5.	You drove a car after having several drinks or after drinking too much	YES	NO	NO ANSWER
6.	You engaged in binge drinking	YES	NO	NO ANSWER

6. Have you ever used substances for recreational purposes such as; marijuana, cocaine, ecstasy, heroin, other mood altering drugs, or prescription drugs? **YES** **NO** **Prefer not to answer at this time**

If NO, go to question 8, if YES please answer the questions below

		YES	NO	Prefer not to answer at this time
A.	At any point, have you ever considered your drug use a problem	YES	NO	NO ANSWER
B.	Do you consider yourself to be in recovery	YES	NO	NO ANSWER

7. Do you currently use substances for recreational purposes such as; marijuana, cocaine, ecstasy, heroin, other mood altering drugs, or prescription drugs? **YES** **NO** **Prefer not to answer at this time**

If NO, go to question 8, if YES please answer the questions below

		YES	NO	Prefer not to answer at this time
A.	Have any of the following happened to you more than once in the last 6 months:			

1. You used drugs even though a doctor suggested that you stop using because of a problem with your health	YES	NO	NO ANSWER
2. You used drugs, were high from drugs, or hungover while you were working, going to school, or other responsibilities	YES	NO	NO ANSWER
3. You missed or were late for work, school, or other activities because you were using drugs or hungover	YES	NO	NO ANSWER
4. You had a problem getting along with other people while you were using drugs	YES	NO	NO ANSWER
5. You drove a car after having using drugs	YES	NO	NO ANSWER

8. In the last 4 weeks, have you experienced any of the following?

	YES	NO	Prefer not to answer at this time
A. Worrying about your health	YES	NO	NO ANSWER
B. Concerned about your weight or how you look	YES	NO	NO ANSWER
C. Little or no sexual desire or pleasure during sex	YES	NO	NO ANSWER
D. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	YES	NO	NO ANSWER
E. Engaged in a behavior that is difficult for you to control	YES	NO	NO ANSWER
F. The stress of taking care of children, parents or other family members	YES	NO	NO ANSWER
G. Stress at work or at school	YES	NO	NO ANSWER
H. Financial issues	YES	NO	NO ANSWER
I. Having no one to turn to when you have a problem	YES	NO	NO ANSWER
J. An upsetting event	YES	NO	NO ANSWER
K. Thinking or dreaming about something bad that happened to you in the past	YES	NO	NO ANSWER

9. Have you ever participated in any type of mental health services before; including couples or family counseling or group therapy? YES NO Prefer not to answer at this time

10. Have you ever been hospitalized for mental health reasons? YES NO Prefer not to answer at this time

11. Are you taking any medication for mental health reasons, including ADHD, anxiety, and depression? YES NO Prefer not to answer at this time

If YES, which medications: ____

12. Are there any physical health issues affecting you at this time?	YES	NO	Prefer not to answer at this time
13. Are there any academic issues affecting you at this time?	YES	NO	Prefer not to answer at this time
14. Are there any current legal issues affecting you at this time?	YES	NO	Prefer not to answer at this time
15. Are there any current social services involvement affecting you at this time?	YES	NO	Prefer not to answer at this time
16. Are you currently in a situation where you have concern for your safety?	YES	NO	Prefer not to answer at this time
17. Have you ever been in a situation where you had concern for your safety?	YES	NO	Prefer not to answer at this time
18. Are you currently in a relationship that involves physical contact, such as hitting, threatening, blocking exits?	YES	NO	Prefer not to answer at this time

19. If you answered YES to any questions on this questionnaire, please circle how difficult these problems made it for you to work, go to school, take care of things at home, or get along with other people?

Not Difficult at All | Somewhat Difficult | Very Difficult | Extremely Difficult

Thank you for filling out this form. Your intake counselor will give you an opportunity to discuss items from this form today.