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Client Questionnaire

Please fill out this form and bring a printed signed copy to your first appointment. This information is confidential and will be used to optimize your care.

Name: _____ Date of Birth: _____ Date: _____

Mailing Address: _____
Home phone: _____
Cell phone: _____
Work phone: _____
Email: _____
Best way to contact you: _____

Marital status. Children: _____

How did you hear about me? _____

Major reason for seeking counseling at this time _____

What are your goals for counseling and any behaviors you would like to change? _____

Check and briefly describe any stressors in your life now: _____

Grief__Sadness__Anxiety__Work__Legal__Financial__School__Family__Friends__
Relationships__Other__.

Medical History: _____

Name/phone of primary physician _____

Have you experienced any of the following in the past year? Check if yes

Depression__ Extreme sadness__	Weight gain/loss__
Panic/Anxiety__	Seizures__
Decreased concentration/memory loss__	Blackouts__
Paranoia/delusional thinking__	Disorientation__
Scary thoughts__	Tremors__
Hallucinations__	Heart palpitations__
Concerns about sexuality__	Diabetes__
Sleep difficulties__	Difficulty breathing__
Obsessive thoughts/Compulsive behaviors__	Stomach/ intestinal problems__
Memory or time lapses__	Disabilities/visual/auditory__
Appetite or eating disturbances__	Other:_____

Please describe any of the problems that you checked above:

Please list any medications you are currently taking:

Medication	Purpose	Dose/Frequency	How long?	MD prescribing
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Previous counseling experience, psychiatric hospitalizations, self harm attempts?

Are you or have you experienced violence including sexual abuse/assault?

Please check and describe briefly if yes: Yes__ No__ Current__ Past__

Are you currently experiencing (or in the past) suicidal thoughts or attempts?

Yes__ No__ If yes please briefly describe.

Has a family member committed suicide or is there a history of mental illness in your family of origin? Please describe

What is your current use of substances?
Please describe amount, frequency, and last time used

Alcohol

Prescription drugs

Recreational drugs

Other ie caffeine, cigarettes, etc,

Do you attend 12 Step Recovery Program? Yes__ No__
If yes, Which one? How long? Regular attendance? Other support groups?

Are there any other medical or mental health issues which would be helpful for your counselor to know?

Please give the name and phone number of one or more trusted persons in your life that I have permission to contact in case I believe you could be a danger to yourself or others.

1. Name/ relation to you
Phone number

2. Name/ relation to you
Phone Number

Client Signature/Date _____

Counselor Signature _____