Dr. Mary T. Bryant, PhD, LMFT, LMHC, PA
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Date: _____

Confidential Client Questionnaire

Name:_____

Date of Birth: _____ Place of Birth: _____

Social Security Number:_____

Parent or Insurance Guarantor:_____

Parent/Guarantor Date of Birth:_____Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone:_____May I contact you at this number? Yes No

Work Phone: _____May I contact you at this number? Yes No

Cell Phone: _____May I contact you at this number? Yes No

Employer: _____

Occupation: _____

Education: _____

Relationship Status: _____ Years: _____

Religious Orientation (if any): _____Currently active?_____

Previous counseling? Yes No If yes, when, where, and what was the problem and the result?_____

_____

_____

Please list any health problems or infectious diseases you have: _____

_____

_____

Name of Physician: _____

Please list all medications that you take (prescribed or over-the-counter): _____

_____

_____

List family and significant others and include name, age, and occupation:

Mother: _____ Father: _____

Are they still married to each other? ____If not, your age at time of divorce or death:____

Sisters: _____

Brothers: _____

Spouse/Partner: _____

Children: _____

Please circle any of the following concerns that pertain to you:

Nervousness	Depression	Fears
Stress	Sexual Problems	Suicidal Thoughts
Communicating	Alcohol/Drug Use	Career Choices
Anger	Hopelessness	Eating Problems
Anxiety	Memory/Concentration	Perfectionism
Fearing Failure	Inferiority Feelings	Self-Control
Self-Confidence	Marriage	Health Problems
Temper	Obsession/Compulsion	Legal Problems
Feeling Worthless	Parent (s)	Being Gay/Lesbian
Guilt	Children	Terminal Illness
Breakup of Relationship	Making Decisions	Death of Loved One
Sleeping	Other: _____	

Has any family member ever had a drinking problem, a nervous breakdown, drug addiction, mental disorder, or attempted suicide? Please describe: _____

_____

_____

_____

Briefly describe your reason (s) for seeking counseling at this time: _____

_____

_____

_____

What is your average *daily* intake of caffeinated drinks? ____ What is your average *weekly* intake of alcoholic drinks? _____ Any recent increase? Yes No

List any drugs you have used, legal or illegal: _____

_____

EAP/Insurance Name, Address, and Phone Number (s): _____

_____

Policy Numbers: _____

_____

Authorization Numbers: _____

_____

Name of Policyholder, if not patient:_____

_____

Driver's License Number and State: _____

Who referred you to me? _____

May I thank this person? Yes No

Emergency Contact Name, Relationship and Phone Number:

_____

Signature: _____ Date:_____