Dr. Christine Bielinski
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Client Information

Please complete this questionnaire to help me plan services for you. **Please answer each item.**

Name _____ Date _____

Date of Birth _____ Age _____ Name you like to be called _____

Address _____

City_____ State _____ Zip Code_____

Home Phone _____ Work Phone _____

Cell _____ Email _____

May I contact you at: Home? ☐ Yes ☐ No **Work?** ☐ Yes ☐ No **Cell?** ☐ Yes ☐ No
Email? ☐ Yes ☐ No **May I add you to my email newsletter list?** ☐ Yes ☐ No

Highest Grade/Degree _____ Type of Degree _____

Area of concentration in your studies _____

Marital/Union Status _____

Spouse/Partner Name _____ Date of Birth _____

Marriage/Union Date: _____

Names of children & ages:

Past Marriages/Significant Relationships: (length, how did it end, children?)

Employer_____

Occupation (former if retired): _____

Does this work satisfy you? ☐Yes ☐No **If not, please explain:**

Primary Care Physician _____Phone No. _____

Any **health problems?**

Medications presently taking (be specific, including supplements, alternative medicines, treatments or herbal remedies). Note dosages, and the condition they are treating.

Exercise: How much? _____ How often? _____

Preferred type of exercise?

Sleep: Note any problems and how long have you had the issue?

Do you smoke? How much? _____ How long? _____ Have you tried to quit? _____
If you've smoked in the past how long has it been since you've smoked? _____

Do you **or any member of your present household** have a current or past issue with **alcohol or drugs**? ☐ Yes ☐ No

Or other addictions (such as internet porn)? ☐ Yes ☐ No

Have you – **or any member of your present household** -- ever received treatment for any kind of addiction or compulsion? ☐ Yes ☐ No Please specify who and what was involved, including any suspicions you might have:

Have you ever been hospitalized for **alcohol, drugs, psychological issues, eating disorders, suicide attempt**? ☐ Yes ☐ No If so, please describe:

Was it helpful? ☐ Yes ☐ No

How much and how often do you currently drink? (per day, per week):

Has anyone in your family (parents, grandparents, siblings, spouse, children, close relatives) had a history of alcohol or drug abuse problems, **significant mental health issues** or other related problems? ☐ Yes ☐ No Please indicate the person and the problem.

Have you received **counseling services** in the past? ☐ Yes ☐ No If so, when? _____

With whom? _____

Why?

Was it helpful? ☐ Yes ☐ No **How? (be specific):**

Religion/Spirituality: How were you raised? _____ What do you currently practice if anything? _____

How important is religion/spirituality to you now? _____

Please describe your **reason for seeking counseling** at this time. Please be as specific as possible. When did it start? _____ **How does it affect you?**

Estimate severity of the problem (Mild, Moderate, Severe, Very Severe) _____

Please explain:

What are **your goals** for our work together?

Goal 1:_____

Goal 2: _____

Goal 3: _____

Goal 4:_____

How will you know if you are meeting your goals? **What would you see yourself doing differently?**

Is there **anything else** you want me to know about you or your special sensitivities that would help our work go more smoothly?

Notify in case of emergency _____ Relationship_____

Phone number(s) _____

Who may I thank for referring you? (optional) _____

_____ _____

Signature Date