THE GRONOWSKI CENTER

A COMMUNITY CLINIC FOR PSYCHOLOGICAL SERVICES

CLIENT QUESTIONNAIRE

CONFIDENTIAL

Welcome to The Gronowski Center. Please complete the following information before your first appointment. Please take the time to fill out this form out carefully. This will help us understand the problems for which you are seeking help and make sure that you receive the best possible treatment.

Name: _____ **Date of Birth:** _____

Gender: ☐ Male ☐ Female ☐ Transgender Male / FTM ☐ Transgender Female / MTF
☐ Genderqueer / Both man and woman / Neither man nor woman ☐ Prefer not to answer

Address: _____

Phone: H: ( ) _____ W: ( ) _____ C: ( ) _____

May we call you at home? ☐ Yes ☐ No Work? ☐ Yes ☐ No On your Cell? ☐ Yes ☐ No

May we leave a message from the clinic at home? ☐ Yes ☐ No Work? ☐ Yes ☐ No Cell? ☐ Yes ☐ No

Can we mail information to you at your home address? ☐ Yes ☐ No

Emergency Contact Information: Name of person to contact in an emergency

Name _____ Address: _____

Phone: H ( ) _____ W ( ) _____ Relationship to you: _____

Insurance Coverage: ☐ Insured-Private Insurance ☐ MediCal ☐ MediCare ☐ Uninsured

Insurance Company Name: _____ Group Number: _____ ID Number: _____

Background Information

Ethnicity (please check):
- ☐ African American
- ☐ Asian American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American
- ☐ Pacific Islander
- ☐ Other (please specify) _____

Marital Status:
- ☐ Never married
- ☐ Living together, not married
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

Sexual Orienta tion *(Optional)*:
- ☐ Bisexual
- Gay/Lesbia
- ☐ Heterosexu
- Other

Education: (Highest grade/degree completed) _____ completed high school _____

Employment History

Currently employed? ☐ Yes ☐ No _____

(If employed) Current Occupation: _____

Current Employer/Company: _____

Approx. Annual Income $_____ Annual Household Income $_____ Total Number of Dependents: _____

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Current Living Situation

Please describe your current living situation (e.g. *living alone, room-mate, family, etc*) _____

_____

_____

Other family members including all dependent children[if applicable]	Age	Gender	Living with you?	Are you the legal guardian? [Yes, No, Not Applicable (NA)]

Please list names and relationships of all other persons that you are living with currently_____

_____

_____

_____

Family History

Briefly describe the family you grew up in, including names and ages of all family members:

_____

_____

_____

Have any family members had a *history* of emotional or psychological problems ☐ Yes ☐ No

If Yes	Relationship to You	List specific emotional or psychological problem
1.		
2.		
3.		
4.		

Have any family members *taken medication* for emotional or psychological problems ☐ Yes ☐ No

If Yes	Relationship to You	List emotional/psychological problem, medication taken, and for how long
1.		
2.		
3.		
4.		

Have any family members *been hospitalized* for emotional or psychological problems ☐ Yes ☐ No

If Yes	Relationship to You	List reason for hospitalization, and how long hospitalized
1.		
2.		
3.		
4.		

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Has any member of your family ever made a suicide attempt? ☐ Yes ☐ No ☐ Unsure

If yes, how is the person related to you?

Has any member of your family died from suicide? ☐ Yes ☐ No ☐ Unsure

If yes, how is the person related to you?

Medical History **Current Primary Care Physician**

Name_____Address _____

Telephone Number_____ Date of last medical / physical exam _____
List any current medical problems _____

Current Medications (please include prescription or over the counter medications with total daily dosage):

Condition	Medication	Dose (mg)	Frequency	Date Started

Current Problems for Which You Are Seeking Help

Are you seeking help for yourself or a family member? Self ☐ Family Member
For what type of counseling or psychological help are you looking? | Individual | Couple Family | Child
Briefly, what brings you (or the client listed above) to treatment at this time? _____

Are you currently seeing a psychiatrist or other mental health practitioner? ☐ **Yes** ☐ **No**
If yes, please complete:

Dates Name of Professional Reason for Treatment Was it helpful?

1. _____
2. _____
3. _____

Are you currently taking any medication for psychiatric or psychological reasons? ☐ **Yes** ☐ **No**
If yes, please list below:

Condition	Medication	Dose (mg)	Frequency	Date Started

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Do you have problems with drugs or alcohol? ☐**Yes** ☐**No** If yes, please give details, such as number of times per week used, substance used, length of time taking substance:

_____

_____

Are you <u>currently</u> having thoughts of suicide? ☐**Yes** ☐**No**
Have you have had thoughts of suicide in the past month ☐**Yes** ☐**No**
Have you have had thoughts of suicide in the past year ☐**Yes** ☐**No**

Previous Treatment History

Have you ever received outpatient psychiatric or psychological treatment before? ☐**Yes** ☐**No**
If yes, please list most recent treatments below:

Dates	Name of Professional	Reason for Treatment	Was it Helpful?

Have you ever been hospitalized for any emotional or psychiatric reason? ☐**Yes** ☐**No**
If yes, approximately how many times? List most recent hospitalizations.

Dates	Name of Hospital	Reason for Hospitalization	Was it Helpful?

Have you ever tried to hurt yourself? Or have you ever made a suicide attempt? ☐**Yes** ☐**No**
If yes, please list below

Dates	What you did to hurt yourself	Were you hospitalized?

Have you <u>ever taken</u> medication for an emotional or mental health problem? ☐**Yes** ☐**No**
If yes, please list below

Medication	Daily Dosage	Reason for med	Name of Provider

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Have you ever received treatment for a drug or alcohol related problem? ☐**Yes** ☐**No**

If yes, please list below

Dates (Mo/Yr)	What of substances were you using?	Type of Treatment (hospital, outpatient program ,AA, NA,etc.	

Have you ever experienced sexual abuse? ☐**Yes** ☐**No**

Have you ever experienced physical abuse? ☐**Yes** ☐**No**

Do you have current legal problems? ☐**Yes** ☐**No**
If YES, please describe:

_____

_____

Have you ever had legal problems? ☐**Yes** ☐**No**
If YES, please describe:

_____

_____

I hereby certify that all information listed above is true to the best of my knowledge. I also certify that I have not purposefully made any misleading comments or supplied incorrect information.

Signed _____ Dated _____

Referral Information: How did you learn about The Gronowski Center?
*Contact Person*_____ *Agency:* _____
Address _____
*City*_____ *Zip Code* _____ *Telephone Number ( )* _____

☐Help Line/Referral Service ☐ Friend ☐ Medical Doctor ☐ Psychiatrist
☐Santa Clara County Mental Health ☐ Kaiser ☐ Psychologist ☐ Social Worker
☐San Mateo County Mental Health ☐ Yellow Pages ☐ Probation Officer ☐ Newspaper
☐Other community clinic [Specify] ☐ Other: _____

Do we have your permission to acknowledge your referral by telephone or mail? ☐**Yes** ☐**No**

Acknowledging your referral will mean that the referring agency or mental health professional will know that you are receiving counseling from The Gronowski Center.

I hereby give you permission to a send a personal thank you letter to the referral source named above:

Signed _____ Dated _____
[Signing here gives us permission to send out a letter acknowledging your referral- we would restrict this to mental health professionals or agencies]