LIFE MANAGEMENT ASSOCIATES, LLC

LMA

NEW CLIENT QUESTIONNAIRE

INSTRUCTIONS: Please answer these questions to help assist us in understanding the client's needs and concerns. If you need additional space to answer any question, please feel free to add additional sheets of paper. If you retain any documents concerning prior treatment, testing, reports, etc. please attach those to this new client questionnaire. When we agree to treat a couple or a family, we consider that couple or family to be the client. We would like each individual included in individual, and couple therapy to complete this form prior to the intake appointment, so that the therapist has background information on all participants. For the purpose of family therapy, we may require new client questionnaires on each individual family member.

Sources of Data Provided Below

☐ Client self-report for all ☐ Client's parent/guardian ☐ A variety of sources: _____

Please check the category below that best matches the client's treatment request.

☐ Individual Adult Issues
☐ Child/Adolescent Issues
☐ Couple/Marriage Issues
☐ Family Issues
☐ Mental Health Evaluation
☐ Child Custody Evaluation
☐ GAL, guardian ad litem services

CLIENT INFORMATION

Client Name (First) _____ (MI) _____ (Last) _____

Address _____

City _____ State _____ Zip _____

Phone #s (Hm) (____) _____ (Wk) (____) _____ (Cell) (____) _____

Email_____

Age _____ Date of Birth ____/____/____

Ethnicity: ☐ Asian ☐ African-American ☐ Native American ☐ White/Caucasian ☐ Other, specify _____

Marital Status: ☐ Single - Never Married ☐ Engaged ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Live in Partner

Sex: F ☐ M ☐

Who was the client referred by? _____

EMERGENCY CONTACT: Name: (Last) _____ (First) _____ (MI) ____

Release Signed? Yes: ☐ No: ☐ , if other than parent/legal guardian.

Cell #: (_____) _____-_____ Home #: (_____) _____-_____ Work #: (_____) _____-_____

Relationship: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify*_____

Cultural/spiritual/religious history

Describe the client's cultural identity (e.g., religion, nationality, family traditions, etc.)

_____

_____

Describe any cultural/spiritual/religious issues that contribute to current problem and/or should be taken into account during treatment

_____

- ☐ currently active in community/recreational activities?
- ☐ formerly active in community/recreational activities?
- ☐ currently engage in hobbies?
- ☐ currently participate in spiritual activities?

If answered "yes" to any of above, describe

_____

_____

PARTNER OR PARENT/LEGAL GUARDIAN INFORMATION

If minor is in state custody, the state representative must complete the appropriate questions within this section.

Name (First) _____ (MI) _____ (Last) _____

Address _____

City _____ State _____ Zip _____

Phone #s (Hm) (____) _____ (Wk) (____) _____ (Cell) (____) _____

Marital Status, ☐ Single– Never Married ☐ Engaged ☐ Married ☐ Divorced ☐ Separated ☐ Live in Partner ☐ Widowed

Sex: F ☐ M ☐ Age _____ Date of Birth ____/____/____

Relationship: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify*_____

OTHER PARTICIPATING FAMILY MEMBERS (List Names and Age)

_____

_____

_____

_____

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NEW CLIENT QUESTIONNAIRE

Presenting Problems

Primary

_____

Secondary

_____

Current Symptom Checklist (Rate intensity of symptoms currently present)

Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning
Severe = Profound impact on quality of life and/or day-to-day functioning

Symptom	Impact				Symptom	Impact			
	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Aggressive Behaviors	☐	☐	☐	☐	Laxative/Diuretic Abuse	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	Loose Associations	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐	Mood Swings	☐	☐	☐	☐
Appetite Disturbance	☐	☐	☐	☐	Obsessions/Compulsions	☐	☐	☐	☐
Bingeing/Purging	☐	☐	☐	☐	Oppositional Behavior	☐	☐	☐	☐
Circumstantial Symptoms	☐	☐	☐	☐	Panic Attacks	☐	☐	☐	☐
Concomitant Medical Condition	☐	☐	☐	☐	Paranoid Ideation	☐	☐	☐	☐
Conduct Problems	☐	☐	☐	☐	Phobias	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	Physical Trauma Perpetrator	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐	Physical Trauma Victim	☐	☐	☐	☐
Dissociative States	☐	☐	☐	☐	Poor Concentration	☐	☐	☐	☐
Elevated Mood	☐	☐	☐	☐	Poor Grooming	☐	☐	☐	☐
Elimination Disturbance	☐	☐	☐	☐	Psychomotor Retardation	☐	☐	☐	☐
Emotional Trauma Perpetrator	☐	☐	☐	☐	Self-Mutilation	☐	☐	☐	☐
Emotional Trauma Victim	☐	☐	☐	☐	Sexual Dysfunction	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐	Sexual Trauma Perpetrator	☐	☐	☐	☐
Fatigue/Low Energy	☐	☐	☐	☐	Sexual Trauma Victim	☐	☐	☐	☐
Generalized Anxiety	☐	☐	☐	☐	Significant Weight Gain/Loss	☐	☐	☐	☐
Grief	☐	☐	☐	☐	Sleep Disturbance	☐	☐	☐	☐
Guilt	☐	☐	☐	☐	Social Isolation	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Somatic Complaints	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	Worthlessness	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	Other	☐	☐	☐	☐

Explanation onset, duration and frequency for any of the symptoms that you have listed above:

Client Emotional/Psychiatric History

☐ ☐ **Client, Prior outpatient psychotherapy?**
No Yes
If yes, on ____occasions. Longest treatment by _____ for ____ sessions from ____/_____ to _____/_____
Provider Name Month/Year Month/Year

Prior provider name	City	State	Diagnosis	Intervention/Modality	Beneficial?

☐ ☐ **Client, Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**
No Yes
If yes, on ____occasions. Longest treatment at _____from _____/_____ to _____/_____
Name of facility Month/Year Month/Year

Inpatient facility name	City	State	Diagnosis	Intervention/Modality	Beneficial?

☐ ☐ **Has the client had suicidal ideation and/or attempts?** If yes, explain suicidal ideation and/or attempts
No Yes

☐ ☐ **Has the client experienced a traumatic event?**
No Yes
If yes, the traumatic event occurred on _____/____
Month/Year

Please describe what occurred during the traumatic event _____

_____

_____

☐ ☐ **Has the client been previously treated for the traumatic event?**
No Yes
If yes, on ____occasions. Longest treatment by _____from _____/_____ to _____/_____
Name of Provider Month/Year Month/Year

Family Emotional/Psychiatric/Substance Abuse History

☐ ☐ **Does any family member have a history of mental illness and or substance abuse? If yes, list all**
No Yes

Name and relationship to client	**Diagnosis**	**Treatment** (e.g., outpatient psychotherapy, inpatient, medication, none)
_____	_____	_____
_____	_____	_____

Family alcohol/drug abuse history

☐ father
☐ mother
☐ grandparent(s)
☐ sibling(s)
☐ other _____
☐ stepparent/live-in
☐ uncle(s)/aunt(s)
☐ spouse/significant other
☐ children

Any other relevant family emotional/psychiatric/substance abuse information, please explain:

_____

_____

_____

_____

_____

_____

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NEW CLIENT QUESTIONNAIRE

Medical History (check all that apply for client)

Describe the client's current physical health ☐ Good ☐ Fair ☐ Poor

description if relevant: _____

_____

List name of primary care physician for the client

Name _____ Phone _____

List name of psychiatrist for the client (if any):

Name _____ Phone _____

Is there a history of any of the following in the family

- ☐ tuberculosis
- ☐ birth defects
- ☐ emotional problems
- ☐ behavior problems
- ☐ thyroid problems
- ☐ cancer
- ☐ mental retardation
- ☐ heart disease
- ☐ high blood pressure
- ☐ alcoholism
- ☐ drug abuse
- ☐ diabetes
- ☐ Alzheimer's disease/dementia
- ☐ stroke
- ☐ other chronic or serious health problems _____

List any known allergies for the client

_____

Describe any serious hospitalization or accidents for the client

Year	Age	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any abnormal lab test results for the client

Year	Result
_____	_____
_____	_____
_____	_____

Clients Sexual history

- ☐ heterosexual orientation
- ☐ homosexual orientation
- ☐ bisexual orientation
- ☐ transgender
- ☐ other _____
- ☐ currently sexually active
- ☐ currently sexually satisfied
- ☐ currently sexually dissatisfied

age first sex experience _____

age first pregnancy/fatherhood _____

history of promiscuity age _____ to_____

history of unsafe sex age _____ to_____

Any additional information pertaining to the clients sexual history, including abuse, assault or perpetrating

_____

_____

_____

_____

_____

_____

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NEW CLIENT QUESTIONNAIRE

Client Mental Health and Other Prescribed Medications

☐ ☐ **Prior or current mental health medication usage? If yes, list below**

No Yes

Medication	Dosage	Frequency	Start Date	End Date	Physician
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List any other medications currently being taken (give reason, including other prescribed medication and over-the-counter)

_____

_____

_____

Please provide any other relevant information, or adverse side effects concerning the use of medications:

_____

_____

_____

_____

Substance Use History (check all that apply for client)

Client Substance use status

- ☐ no history of abuse
- ☐ active abuse
- ☐ early full remission
- ☐ early partial remission
- ☐ sustained full remission
- ☐ sustained partial remission

Client Treatment history

- ☐ Outpatient (age[s]) _____
- ☐ Inpatient (age[s]) _____
- ☐ 12-step program (age[s]) _____
- ☐ stopped on own (age[s]) _____
- ☐ other (age[s]) _____ _____

Client Substances used	First use age	Last use age	Current Use	Frequency	Amount
☐ alcohol	_____	_____	☐	_____	_____
☐ amphetamines/speed	_____	_____	☐	_____	_____
☐ barbiturates/owners	_____	_____	☐	_____	_____
☐ cocaine	_____	_____	☐	_____	_____
☐ crack cocaine	_____	_____	☐	_____	_____
☐ hallucinogens (e.g., LSD)	_____	_____	☐	_____	_____
☐ inhalants (e.g., glue, gas)	_____	_____	☐	_____	_____
☐ marijuana or hashish	_____	_____	☐	_____	_____
☐ opioids	_____	_____	☐	_____	_____
☐ PCP	_____	_____	☐	_____	_____
☐ prescription	_____	_____	☐	_____	_____
☐ other	_____	_____	☐	_____	_____

Consequences of substance abuse

- ☐ hangovers
- ☐ seizures
- ☐ blackouts
- ☐ Accidental overdose
- ☐ binges
- ☐ withdrawal symptoms
- ☐ medical conditions
- ☐ Increase in tolerance
- ☐ loss of control over amount used
- ☐ job loss
- ☐ sleep disturbance
- ☐ assaults
- ☐ suicide attempts
- ☐ suicidal impulse/thoughts
- ☐ relationship conflicts
- ☐ arrests
- ☐ other _____

Client Family History

Client Family of Origin

Present during childhood

	Present entire childhood	Present part of childhood	Not Present at all
mother	☐	☐	☐
father	☐	☐	☐
stepmother	☐	☐	☐
stepfather	☐	☐	☐
brother(s)	☐	☐	☐
sister(s)	☐	☐	☐
other	☐	☐	☐

NEW CLIENT QUESTIONNAIRE

Client's Parents' current marital status

- ☐ married to each other
- ☐ separated for ____ years
- ☐ divorced for ____ years
- ☐ mother remarried ____ times
- ☐ father remarried ____ times
- ☐ mother involved with someone
- ☐ father involved with someone
- ☐ mother deceased for____ years
  - age of client at mother's death ____
- ☐ father deceased for ____ years
  - age of client at father's death ____

Describe childhood family experience for the client

- ☐ outstanding home environment
- ☐ normal home environment
- ☐ chaotic home environment
- ☐ witnessed physical/verbal/sexual abuse toward others
- ☐ experienced physical/verbal/sexual abuse from others

Client age of emancipation from home: _____, reason: _____

Client special circumstances in childhood [anything you believe is relevant about your childhood history]

_____

_____

_____

Client Immediate Family

Client marital status

- ☐ single, never married
- ☐ engaged _____ months
- ☐ married for _____ years
- ☐ divorced for _____ years
- ☐ separated for ___ years
- ☐ divorce in process _____ months
- ☐ spouse/partner deceased for ____ years
- ☐ live-in for _____ years
- ☐ _____ prior marriages (self)
- ☐ _____ prior marriages (partner)

Client relationship satisfaction

- ☐ very satisfied with relationship
- ☐ satisfied with relationship
- ☐ somewhat satisfied with relationship
- ☐ dissatisfied with relationship
- ☐ very dissatisfied with relationship

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NEW CLIENT QUESTIONNAIRE

List all persons currently living in client's household

Name	Age	Sex	Relationship to Client
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

List biological/adopted children not living in same household as patient

Name	Age	Sex	Relationship to Client
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

Describe any past or current significant issues in intimate relationships, the client may have: _____

_____

_____

_____

_____

Client Socio-Economic History (check all that apply)

Living situation

- ☐ housing adequate
- ☐ homeless
- ☐ housing overcrowded
- ☐ dependent on others for housing
- ☐ housing dangerous/deteriorating
- ☐ living companions dysfunctional

Social support system

- ☐ supportive network
- ☐ few friends
- ☐ substance-use-based friends
- ☐ no friends
- ☐ distant from family of origin

Military

- ☐ never in military
- ☐ served in military - no incident
- ☐ served in military - with incident

Client Developmental History (check all that apply for the client)

Client problems during mother's pregnancy

- ☐ none
- ☐ high blood pressure
- ☐ kidney infection
- ☐ German measles
- ☐ emotional stress
- ☐ bleeding
- ☐ alcohol use
- ☐ drug use
- ☐ cigarette use
- ☐ other

Client birth

- ☐ normal delivery
- ☐ difficult delivery
- ☐ cesarean delivery
- ☐ complications

_____

_____

birth weight _____ lbs. _____oz.

Client infancy problems

- ☐ none
- ☐ feeding problems
- ☐ sleep problems
- ☐ toilet training problems

Client delayed developmental milestones (check only those milestones that did not occur at expected age):

- ☐ sitting
- ☐ rolling over
- ☐ standing
- ☐ walking
- ☐ feeding self
- ☐ speaking words
- ☐ speaking sentences
- ☐ controlling bladder
- ☐ controlling bowels
- ☐ sleeping alone
- ☐ dressing self
- ☐ engaging peers
- ☐ tolerating separation
- ☐ playing cooperatively
- ☐ riding tricycle
- ☐ riding bicycle

☐ other _____

Client emotional / behavior problems during childhood (check all that apply):

- ☐ none
- ☐ drug use
- ☐ alcohol abuse
- ☐ chronic lying
- ☐ stealing
- ☐ violent temper
- ☐ fire-setting
- ☐ hyperactive
- ☐ animal cruelty
- ☐ assaults others
- ☐ disobedient
- ☐ repeats words of others
- ☐ not trustworthy
- ☐ hostile/angry mood
- ☐ indecisive
- ☐ immature
- ☐ bizarre behavior
- ☐ self-injurious threats
- ☐ frequently tearful
- ☐ lack of attachment
- ☐ distrustful
- ☐ extreme worrier
- ☐ self-injurious acts
- ☐ impulsive
- ☐ easily distracted
- ☐ poor concentration
- ☐ often sad
- ☐ breaks things in anger
- ☐ Withdraws/avoids interactions with others

☐ other _____

Client social interaction during childhood (check all that apply)

- ☐ normal social interaction
- ☐ isolates self
- ☐ very shy
- ☐ alienates self
- ☐ inappropriate sex play
- ☐ dominates others
- ☐ associates with acting-out peers

☐ other _____

Client intellectual / academic functioning

- ☐ normal intelligence
- ☐ high intelligence
- ☐ learning problems
- ☐ authority conflicts
- ☐ attention problems
- ☐ underachieving
- ☐ mild retardation
- ☐ moderate retardation
- ☐ severe retardation

LIFE MANAGEMENT ASSOCIATES, LLC

NEW CLIENT QUESTIONNAIRE

Client's current or highest education level _____

Describe any other developmental [physical, emotional, behavioral, social, intellectual or academic] problems or issues, the client may have had during childhood.

_____

_____

_____

_____

_____

Client Employment

- ☐ employed and satisfied
- ☐ employed but dissatisfied
- ☐ Employed full time
- ☐ Employed part time
- ☐ Disabled:

_____

Current Occupation

_____

Current Employer

_____

Location

_____

Client Financial Situation

- ☐ no current financial problems
- ☐ large indebtedness
- ☐ poverty or below-poverty income
- ☐ impulsive spending
- ☐ relationship conflicts over finances

- ☐ Coworker conflicts
- ☐ Supervisor conflicts
- ☐ Unstable work history

Client Legal History

- ☐ no legal problems
- ☐ now on parole/probation
- ☐ arrest(s) not substance-related
- ☐ arrest(s) substance-related
- ☐ court ordered this treatment
- ☐ jail/prison _____ time(s)

  total time served: _____

Describe Any Client Legal Difficulties

_____

_____

_____

_____

_____

_____

_____

Strengths/Limitations:

The client exhibits the following strengths, check all that apply?

- ☐ Accepts Guidance/Feedback
- ☐ Calm
- ☐ Capable of Independence
- ☐ Clear Thinking
- ☐ Confident
- ☐ Cooperative
- ☐ Expressive/Articulate
- ☐ Good Personal Care Habits
- ☐ Insightful
- ☐ Integrated Moral Values
- ☐ Intelligent
- ☐ Motivated for Change
- ☐ Physically Healthy
- ☐ Positive Support Network
- ☐ Reasonable Judgment
- ☐ Reliable
- ☐ Responsible
- ☐ Sociable
- ☐ Stable Living Environment
- ☐ Stable Work History
- ☐ Supportive Family
- ☐ Varied Interests

Other *explain*: _____

The client exhibits the following weaknesses, check all that apply?

- ☐ Aggressive
- ☐ Chaotic Living
- ☐ Concrete Thinking
- ☐ Defensive
- ☐ Demanding
- ☐ Dependent
- ☐ Distrustful
- ☐ Easily Distracted
- ☐ Hostile
- ☐ Illiterate
- ☐ Impulsive
- ☐ Indecisive
- ☐ Intellectual Deficits
- ☐ Irresponsible
- ☐ Lacks Insight
- ☐ Lacks Moral/Ethical Values
- ☐ Lacks Social Skills
- ☐ Needs Close Supervision
- ☐ Negative Peer Group
- ☐ No Support Network
- ☐ Non-Supportive Family
- ☐ Not Motivated to Change
- ☐ Not Open/Articulate
- ☐ Poor Health
- ☐ Poor Hygiene/Grooming
- ☐ Poor Judgment
- ☐ Unreliable
- ☐ Unstable Employment History
- ☐ Very Narrow Interests

Other *explain:* _____

NEW CLIENT QUESTIONNAIRE

Does the client have any additional issues or concerns not previously identified by any of the prior questions?

If so, please explain below:

2510 Continental Drive • Butte, MT 59701 • Phone: 406-782-4778 • Fax: 406-782-1318

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NEW CLIENT QUESTIONNAIRE

COMMUNICATION AUTHORIZATION

Confidentiality of E-mail, Voice Mail, and Fax Communication: E-mail, voice mail, and fax communication can be accessed by unauthorized people, compromising the privacy and confidentiality of such communication. LMA cannot guarantee confidentiality of e-mail, voice mail, and fax communication. If you choose to communicate confidential information with LMA via e-mail, voice mail, and fax communication, LMA will assume that you have made an informed decision and LMA will view it as your agreement to take the risk that e-mail, voice mail, and fax communication may be intercepted.

Understanding the above information, please indicate your communication preferences.

OK to send mail?	Yes ☐ No ☐	OK to send email?	Yes ☐ No ☐
OK to call cell?	Yes ☐ No ☐	OK to leave voicemail message on cell?	Yes ☐ No ☐
OK to call home?	Yes ☐ No ☐	OK to leave voicemail message at home?	Yes ☐ No ☐
OK to call work?	Yes ☐ No ☐	OK to leave voicemail message at work?	Yes ☐ No ☐
OK to text cell?	Yes ☐ No ☐		

The client/parent/legal guardian requests and consents to the following services:

☐ Mental health evaluation, interpretation of results, & preparation of reports

☐ Counseling/Psychotherapy (individual, couples, family, or group)

☐ Family systems evaluation, interpretation of results, & preparation of reports

☐ Child custody evaluation, interpretation of results, & preparation of reports

☐ GAL, guardian ad litem services

☐ Other services: _____

I attest that the information provided in or attached to this questionnaire is complete, accurate, and true to the best of my knowledge.

_____ ____/____/____

Client Signature Date

_____ ____/____/____

Parent/Legal Guardian Signature [*mandatory if client is a minor*] Date

_____ ____/____/____

Therapist/Representative of Life Management Associates, LLC Date

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