LifePointe
Counseling, LLC

Healing Hearts ✧ Restoring Hope

CLIENT QUESTIONNAIRE

Please complete as much of this information as possible and give this form to your health care provider at your first visit. Please note that if the provider you are seeing is on your insurance panel, we must have a copy of your current insurance information prior to your first visit. Some insurance companies will not cover your visit if it has not been pre-certified. Please make every effort to know and understand your mental health insurance benefits prior to your visit(s) to LifePointe Counseling, LLC.

Name: ______________________________ **Date:** ______________

Please give us a brief description of your need for counseling:

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Please answer the following questions by circling either Yes or No. If Yes, please provide a brief description of the problem area:

Anxiety/Stress – Yes or No

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Uncomfortable in Social Settings – Yes or No

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Compulsions/Addictions – Yes or No

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Appetite Changes – Yes or No

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Sleep Changes – Yes or No

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Concentration/Focus Problems – Yes or No

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Work/School Impairment – Yes or No

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Difficulty Caring for Self/Family/Home/Children – Yes or No

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Family Conflicts – Yes or No

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Spiritual Problems – Yes or No

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Depression – Yes or No

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Feelings of Hopelessness/Despair – Yes or No

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Self-Harm – Yes or No

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Suicidal Thoughts – Yes or No

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Suicidal Plans – Yes or No

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Suicidal Attempts – Yes or No

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Previous Hospitalization – Yes or No

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Previous Counseling – Yes or No

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Current Counseling – Yes or No

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Medication History (Please list current medications here. To provide a thorough history, use page 3.)

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THOROUGH MEDICATION HISTORY

Medication Name (Please Include Dosage/Mg)	Date(s) Prescribed/Taken	Side Effects