Jefferson and Associates Psychological Services, P.C.
3712 Old Forest Road, Suite 500
Lynchburg, Virginia 24501
(434) 385-0744

Individual Client Information Questionnaire

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully or ask your therapist for clarification if you do not understand an item.

Full Name: _____ Today's Date: _____

Mailing Address: _____ (city/state) _____ (zip) _____

Physical Address: _____ (city/state) _____ (zip) _____

Telephone: _____ _____ _____
(Home) (Work) (Cell phone)

Age: _____ Date of Birth: _____ Marital Status: _____

Social Security #: _____ Place of Employment: _____

Briefly describe your reason for seeking help: _____

_____

Who referred you to us? _____

Family Physician: _____ Date of last office visit: _____

List any major health problems for which you are currently receiving treatment: _____

_____

List any medications you are currently taking (including herbal remedies): _____

_____

Have you ever received psychiatric or psychological help or counseling of any kind before? _____

If so, please state where, when and with whom: _____

_____

Has anyone in your family received treatment for or been diagnosed as having a mental illness, alcohol or drug problem? If **yes** specify: _____

_____

Note any major illnesses, hospitalizations, surgeries and injuries: _____

_____

Note any significant occupational/educational issues (ie. work problems, reading problems): _____

_____

Please **circle** any of the following problems which pertain to you:

Anxiety	Depression	Sleep
Shyness	Suicidal Thoughts	Energy
Relaxation	Alcohol Use	Memory
Inferiority Feelings	Drug Use	Nightmares
Loneliness	Panic	Appetite
Stress	Confusing Thoughts	
Anger	Bowel Trouble	Legal Matters
Sexual Problems	Stomach Trouble	Finances
Self-Control	Headaches	Dealing with Family Members
Decision Making	Back Trouble	Divorce
Concentration		Career Choices

Name:	Age:	Marital Status:	Occupation:	Health Problems:
(Spouse)				
(Children)				
(Parents)				
(Siblings)				

Please list any other information which you feel may be helpful to us: _____

_____

Insurance Company Name: _____ Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Thank you for your cooperation in completing this questionnaire.

_____ _____

(Signature) (Date)