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

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.

Child's Full Name: ____ Today's Date: __________________

Mailing Address: ___________________________________ (city/state) ____________________ (zip) ____________

Physical Address: ___________________________________ (city/state) ____________________ (zip) ____________

Telephone: __________________ (Home) ____________________ (Father's work) ____________________ (Mother's work) ____________________ (Cell phone)

Child's Birth Date: ______________________ Child's Social Security#: _________________________

Father's Name: ____ Social Security #: ______________________

Mother's Name: ____ Social Security #: _______________________

Name of School: ____Grade: _______________

If parent are separated/divorced, who has custody: ____

Briefly describe your reason for seeking help: ____

____

Who referred you to us? ____

List any major health problems for which he/she is currently receiving treatment: _________________________

____

List any medications he/she is currently taking (including herbal remedies): _____________________________

____

Has your child 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 disease, disorder, alcohol or drug problem? If **yes** specify: ____

____

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

____

Note any significant developmental issues (ie. prematurity, walk early, talk late): _________________________

____

Note any significant problems/issues in educational history: ____

____

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

Nervousness	Education	Memory	Self Control
Fears	Temper	Insomnia	Stress
Anger	Stomach Trouble	Inferiority Feelings	Headaches
Depression	Friends	Career Choices	Ambition
Unhappiness	Shyness	Nightmares	Making Decisions
Work	Divorce	Bowel Trouble	Concentration
Tiredness	Separation	Suicidal Thoughts	Health Problems
Energy	Sleep	Sexual Problems	Appetite
Loneliness	Relaxation	Alcohol Use	Other:____________

Name:	Age:	Marital Status:	Occupation/Grade:	Health Problems:
(Parents)				
(Siblings)				
(Other's in home)				

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 of parent/ legal guardian)

______________________ (Date)