Tiffany T. Conyers, LCSW
Prenatal and Postpartum Counseling & Resources For Women
1300 Ridenour Blvd NW, Suite 100
Kennesaw, GA 30152

Client Questionnaire

Client's Name:_____Today's Date:_____

Address, City, State, Zip: _____

Home phone:_____Work phone:_____Cell phone: _____

Private email address:_____Student? If yes, where and major?_____

May I leave messages for you at home? Yes / No May I leave messages for you at work? Yes / No

Gender: M / F Age:_____ Birth Date:_____ Marital Status:_____

Others Living in Home (name, age, relationship to client):_____

_____

Highest Level of Education:_____Occupation:_____

Client's Employer: (optional)_____

Emergency Contact:_____Relationship to client:_____Phone:_____

Referred by/ How did you hear about my services?_____

Have you received previous counseling and/or substance abuse treatment? Yes_____No _____

If Yes, Name & number of therapist/Agency: (optional)_____

Past Diagnoses?_____Month /Years in treatment: _____

Name & number of primary care physician or health practitioner (optional)_____

Name & number of psychiatrist or psychiatric nurse practitioner:(optional) _____

Any current medical or mental health conditions being treated? _____

Any current medications? Yes_No___[If yes, please list & include daily dose amounts]_____

_____

Do we have your permission to discuss or receive treatment records and/or to receive diagnostic records from your past or current therapist, psychiatrist, and/or physician and/or to disclose or share our clinical information with your past or current therapist, psychiatrist, and/or physician? Yes No

Signature [required]_____**Date** [required] _____

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Personal & Family Information

Ethnic identity & background_____Current relationship status_____

My birth parents currently:

married/live together____separated____divorced_____never lived together_____one or both deceased _____

Family of Origin [parents/step parents, adoptive parents, siblings]

Name (optional)	**Relationship to you**	**Age or deceased**

Current Family & Household [partner/spouse, roommates, children]

Name (optional)	**Relationship to you**	**Age or deceased**

Check all that apply:

(History of)	**Family of Origin**	**Current Family & Household**
Counseling		
Alcohol dependence		
Drug dependence		
Chronic physical illness		

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(History of)	**Family of Origin**	**Current Family & Household**
Chronic mental illness	_____	_____
Depression	_____	_____
Anxiety	_____	_____
Sexual abuse and/or incest	_____	_____
Psychiatric hospitalization	_____	_____
Suicide attempts	_____	_____
Eating Disorders	_____	_____
Domestic Violence	_____	_____

(check all that apply)

- I use alcohol: never__less than once per week___more than once per week____daily____
- I use drugs: never___less than once per week___more than once per week____daily____
- I use tobacco: never__less than once per week___more than once per week____daily____
- I have experienced an unwanted sexual experience: recently_____ in the past_____sexual assault date:_____ incest: _____
- My sleep is:_____hours a night / Frequent waking? (y/n) / Difficulty falling asleep? (y/n) Staying asleep? (y/n)
- I am dissatisfied with my personal appearance (y/n)
- I have felt like or tried to hurt myself in the past (y/n) I'm currently hurting myself (y/n)
- I have suffered a recent significant loss or death (y/n)
- I have suffered a recent relationship ending (y/n) other loss (y/n) (Please list)_
- I have experienced:

___(y/n) medical complications at birth

___(y/n) serious head injury (or knocked out)

___(y/n) past learning disability or attention deficit/hyperactivity disorder

___(y/n) permanent disability (if checked yes, please describe) _____

___(y/n) legal difficulties (if checked yes, please describe) _____

Maternal inSync

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Reproductive History

Are you:

Trying to conceive?	Y/N	For How long: ____ (weeks/months/years)
Currently Expecting?	Y/N	How many weeks:_____
Adopting a Child(ren)?	Y/N	Describe: _____

Have you experienced:

Pregnancy Loss?	Y/N	How Many: _____	When: _____
Abortion?	Y/N	How Many: _____	When: _____
C-Section?	Y/N	How Many: _____	When: _____
IVF Treatment	Y/N	How Many: _____	When: _____

How many living children do you have:_____ Ages: _____

Please state briefly your reasons for seeking services at this time.

What do you think may be getting in the way of you resolving your current problems or concerns?

What are a few of your current goals that you wish to achieve while participating in counseling and how do you currently believe you can best achieve those goals?

How would you like things to be different after you have participated in counseling/consultation?

If you could wake up tomorrow with a different life or in a different situation, what would that life look like?