

HealthQuest
CLIENT INFORMATION QUESTIONNAIRE

Name: _____ Date: _____

Address: _____

Telephone: (Home) _____ / (Work) _____

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

Occupation: _____ Employer: _____

Briefly describe your reason for seeking help _____

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

Nervousness	Depression	Fear
Shyness	Sexual Problems	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self Control	Unhappiness
Steep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Stomach Problems
Bowel Troubles	Being a Parent	My Thoughts

Who Suggested You Seek Treatment? _____
