Eva Giedt PMH NP
183 Sargent Court rear
Monterey CA 93940
EvaG97@aol.com
831-236-7110

Client Questionnaire

Please fill out this form and bring a printed signed copy to your first appointment. This information is confidential and will be used to optimize your care.

Name: Date of Birth: Date:

Mailing Address:

Home phone:
Cell phone:
Work phone:
Email:
Best way to contact you:

Marital status. Children:

How did you hear about me?

Major reason for seeking counseling at this time

What are your goals for counseling and any behaviors you would like to change?

Check and briefly describe any stressors in your life now:

Grief__Sadness__Anxiety__Work__Legal__Financial__School__Family__Friends__
Relationships__Other__.

Medical History:
Name/phone of primary physician_____

Have you experienced any of the following in the past year? Check if yes

Depression__Extreme sadness__	Weight gain/loss__
Panic/Anxiety__	Seizures__
Decreased concentration/memory loss__	Blackouts__
Paranoia/delusional thinking__	Disorientation__
Scary thoughts__	Tremors__
Hallucinations__	Heart palpitations__
Concerns about sexuality__	Diabetes__
Sleep difficulties__	Difficulty breathing__
Obsessive thoughts/Compulsive behaviors__	Stomach/ intestinal problems__
Memory or time lapses__	Disabilities/visual/auditory__
Appetite or eating disturbances__	Other:_____

Please describe any of the problems that you checked above:

Please list any medications you are currently taking:

Medication	Purpose	Dose/Frequency	How long?	MD prescribing

Previous counseling experience, psychiatric hospitalizations, self harm attempts?

Are you or have you experienced violence including sexual abuse/assault?
Please check and describe briefly is yes: Yes__ No__ Current__ Past__

Are you currently experiencing (or in the past) suicidal thoughts or attempts?
Yes__ No__ If yes please briefly describe.

Has a family member committed suicide or is there a history of mental illness in your family of origin? Please describe

What is your current use of substances?
Please describe amount, frequency, and last time used

Alcohol

Prescription drugs

Recreational drugs

Other ie caffeine, cigarettes, etc,

Do you attend 12 Step Recovery Program? Yes__ No__
If yes, Which one? How long? Regular attendance? Other support groups?

Are there any other medical or mental health issues which would be helpful for your counselor to know?

Please give the name and phone number of one or more trusted persons in your life that I have permission to contact in case I believe you could be a danger to yourself or others.

1. Name/ relation to you
   Phone number

2. Name/ relation to you
   Phone Number

Client Signature/Date_____

Counselor Signature _____