Catholic Charities

Providing Help
Creating Hope

Catholic Charities of the Diocese of Raleigh, Inc.

Client Questionnaire For Counseling Services

For each person participating in the counseling, please complete a client questionnaire. Your answers will help your counselor provide the best possible services for you. Thank you.

Name_____ Date of completion: _____

Why have you come to counseling now? *(Please complete if there was not enough space on the Intake Sheet)*

_____

_____

_____

_____

Counseling History:

- Have you ever been involved with counseling before? _____ yes _____no

  If so, with whom_____ when & how long?_____
- Was counseling helpful in the past? ____ yes ____ no

  Please explain_____
- Have you ever been hospitalized for mental health treatment? _____ yes _____ no

  If so, where? _____ and when? _____

  Was the hospitalization helpful in the past? ____ yes ____ no Please explain _____

  _____

Medical History:

Name of primary physician: _____ Telephone number: _____

Address: _____

Please list any significant current or past health problems: _____

_____

_____

_____

_____

Please list the current medications you are taking, if any:

Medication	Amount	Frequency	Reason

OVER, PLEASE

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Substance Use/Abuse History:

	Method & Amount	Frequency of Use	Have you used these substances within the past 48 hrs?	Have you used these substances within the past 30 days?	Do you have a history of abuse with these substances?
Alcohol			**Y / N**	**Y / N**	**Y / N**
Amphetamines			**Y / N**	**Y / N**	**Y / N**
Barbiturates			**Y / N**	**Y / N**	**Y / N**
Sedatives (Valium/ Librium)			**Y / N**	**Y / N**	**Y / N**
Cocaine/ Crack			**Y / N**	**Y / N**	**Y / N**
Opiates			**Y / N**	**Y / N**	**Y / N**
Cannabis (Marijuana)			**Y / N**	**Y / N**	**Y / N**
Hallucinogens (PCP/ LSD)			**Y / N**	**Y / N**	**Y / N**
Inhalants			**Y / N**	**Y / N**	**Y / N**
Nicotine & Caffeine			**Y / N**	**Y / N**	**Y / N**
Over the counter			**Y / N**	**Y / N**	**Y / N**
Prescription			**Y / N**	**Y / N**	**Y / N**
Other: _____			**Y / N**	**Y / N**	**Y / N**

- Has anyone ever told you they wished you did not use, or have you ever felt you should stop using or cut down on using one of the above substances? ____ yes ____ no

  If yes, please check any of the following: ___ employer ___ children ___ spouse/partner ___ legal ___ other: _____

- Have people annoyed you by criticizing your drinking? ____ yes ____no
- Have you ever felt bad or guilty about your use of one of the above substances? ____ yes ____ no
- Have you ever used one of the above substances first thing in the morning to steady your nerves or to get rid of a hangover (as an "eye opener")? ____ yes ____ no
- Have you been hospitalized for substance abuse treatment? ____ yes ____ no

  If so, where? _____ and when? _____

  Was the hospitalization helpful? ____ yes ____ no Please explain _____

  _____

Is there anything else that you want your counselor to know about you or your current situation?

_____

_____

When you have completed your counseling how will your life be changed?

_____

_____