Family Service Madison

Client Information

DEMOGRAPHICS

Name: _____

If under 18 years old, name of legal guardian: _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ N/A

Date of Birth: _____ **Age:** _____

Address: _____ **Apt**: _____

City/State: _____ **Zip:** _____

Do you reside in:

___ City of Madison ___ Dane County ___Outside of Dane County ___N/A

Email Address: _____

Phone: Cell: _____ **Is it okay to call or leave a message:** ____ Yes ____ No

Home: _____ **Is it okay to call or leave a message:** ____ Yes ____ No

How would you prefer appointment reminders?

___ I do not want appointment reminders ___ Phone call ___ Text ___ Email

Referral Source:

Who referred you to FSM? ☐ Self ☐ County ☐ DPU ☐ PO ☐ Other _____

Referral Source Name: _____

Referral Source Phone Number: _____

Do you have a disability/handicap: ___ Yes ___ No ___ N/A

Race:

☐ African American
☐ Asian
☐ SE Asian
☐ Biracial or multiracial
☐ Latino/a
☐ Native American
☐ White
☐ Other: _____
☐ N/A

Projected Annual Income:

☐ Free and Reduced Lunch
☐ Non-needy
☐ Less than $11,999
☐ $12,000 to $23,999
☐ $24,000 to $35,999
☐ $36,000 to $49,999
☐ $50,000+

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Education:

- ☐ High school diploma
- ☐ G.E.D. diploma
- ☐ Bachelor's degree
- ☐ Technical courses beyond high school
- ☐ Associate degree
- ☐ Masters degree
- ☐ Other: _____

Relationship Status:

- ☐ Single
- ☐ Dating
- ☐ Partnered
- ☐ Engaged
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Remarried
- ☐ Widowed
- ☐ Child

DATE: _____

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Personal History

- The following are questions asked of all clients at Family Service Madison.
- The information you provide will assist your therapist in getting to know you as quickly as possible.
- Please answer **ALL** questions as completely as possible. Your answers are confidential and will not be shared with anyone outside the clinic without your written consent.

- **FAMILY HISTORY**

Please list your caregivers/parents:

Name	Relation to you	Living or Deceased ?	Age	How often do you see or get in contact with this person?	Highest grade level completed in school?

Siblings/Brothers & Sisters:

Name	Relation to you	Living or Deceased ?	Age	How often do you see or get in contact with this person?

Did you move a lot while growing up? How many times? _____

Other History:

Family History of Mental Illness: _____

_____

Family History of Drug/Alcohol Abuse: _____

_____

- **SOCIAL NETWORK**

Other than your partner or children who do you feel closest to? (Specify friends or relative): _____

_____

Who would you rely on if you needed help: _____

_____

On a scale of 1 - 10 if **1=very isolated** and **10=very connected**, how connected do you feel? _____

- **RELATIONSHIP HISTORY**

Sexual Attraction to/relationship history with: ☐ Men ☐ Women ☐ Men and Women

Are you currently involved in a significant relationship? ☐ Yes ☐ No

For how long? _____

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Dates of long-term/significant relationships (include current relationship):

Partner Name	Date Met	Lived Together? (Y/N)	Married? (dates)	Separated, broke up, or divorced? When?

Describe patterns or issues that you view as problematic in your past relationships: _____

_____

Describe your current relationship: _____

_____

❖ **HOUSEHOLD INFORMATION**

List all the people you live with, and their relationship to you:

Name	Age	Relationship

Please list all names and ages of your biological children and/or the children you provide care for:

Name	Age	Relationship

Is there a co-parent or caregiver to children listed above who is not your current partner? ☐ Yes ☐ No

Describe what your relationship is like with your children: _____

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❖ **PREVIOUS TREATMENT/THERAPY**

Please list all mental health or substance abuse treatment you have received

Treatment Provider/Facility/Program (Begin with the most recent treatment first.)	Dates	Problem/Reason	Outcome/Completion?

❖ **HISTORY OF ALCOHOL AND/OR DRUG USE**

Check **ALL** substances that you have **USED RECREATIONALLY**:

☐ Alcohol	☐ Marijuana	☐ Crack	☐ Freebasing Cocaine
☐ Mescaline	☐ LSD	☐ PCP	☐ Sedatives (Downers)
☐ Codeine	☐ Heroin	☐ Methadone	☐ Amphetamines (Speed)
☐ Cocaine	☐ Quaaludes	☐ Painkillers	☐ Psilocybin (Mushrooms)
☐ Peyote	☐ Snorting	☐ IV Cocaine	☐ Inhalants (Gas, Paint Thinner etc)

What is your substance of choice: _____

Frequency of use: _____

How does it influence your behavior: _____

_____

Do you think you have a substance abuse problem? ☐ Yes ☐ No

❖ **EDUCATION**

In your opinion, were you a good student? ☐ Yes ☐ No

Attendance Problems? ☐ Yes ☐ No

Special Education classes? ☐ Yes ☐ No

Did you have behavior problems (including conflicts, fights, suspensions and expulsions)? _____

_____

_____

❖ **ABUSE HISTORY**

Please list any history of physical, sexual, emotional abuse (include information as victim, perpetrator, or affected family member): _____

_____

_____

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❖ **LEGAL STATUS AND HISTORY**

Have you ever been arrested as a **juvenile**: ☐ Yes ☐ No

If yes, please list the charges and the outcome: _____

_____

Have you ever been arrested as an **adult**: ☐ Yes ☐ No

If yes, please list the charges and dates they occurred: _____

_____

Have you ever served time in jail or prison: ☐ Yes ☐ No

If yes, please explain: _____

Are you currently on probation/parole? ☐ Yes ☐ No

Have you ever been on probation/parole? ☐ Yes ☐ No

Do you have any charges pending? ☐ Yes ☐ No

Do you have a restraining order against you? ☐ Yes ☐ No

Other significant legal information: _____

❖ **EMPLOYMENT/FINANCIAL**

Currently employed? ☐ Yes ☐ Full Time ☐ Part Time ☐ No

If yes, what is your current job: _____

Given your abilities and training do you think you should have a better job? ☐ Yes ☐ No

If yes, what job: _____

Please briefly list your significant employment history:

Previous jobs	Reason for leaving	Length of employment

Have you been having financial problems recently? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

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❖ **STRENGTHS AND ADDITIONAL INFORMATION**

What are your **strengths**? _____

_____

_____

What are your **hobbies**? _____

_____

_____

What are the things you do to **take care** of yourself or stay **healthy**? _____

_____

_____

Do you identify with a certain **spirituality** or **religion?** If so, what? _____

_____

_____

Is there anything else that would be helpful for your therapist to know about you? ☐ Yes ☐ No

_____

_____

_____

I certify that all answers to the questions on this questionnaire are true to the best of my knowledge.

Client Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____