# Client Questionnaire

Please answer the questions below to the best of your ability. All information you provide will be kept in strict confidentiality.

BASIC INFORMATION

Name: ________________________________________ DOB: __________________________

Today's Date: ________________________ Referred by: __________________________________

Home Phone: _________________________ May I leave a message at this number? ◻Yes ◻No

Cell Phone: ___________________________ May I leave a message at this number? ◻Yes ◻No

Other Phone: __________________________ May I leave a message at this number? ◻Yes ◻No

Home Address:

Street: ____________________________________ City/State: ___________________________

Zip: __________ E-mail address: _____________________________________________________

PERSONAL INFORMATION

1. Relationship Status:
   ◻ Single ◻ In committed relationship ◻ Married
   ◻ Separated ◻ Divorced ◻ Widowed

2. Please list spouse/partner's name and length of relationship: _______________________

3. On a scale of 1-10, how would you rate your relationship? _________________________

4. Do you have children? ◻Yes ◻No
   List names and ages: ____________________________________________________

5. Do you have siblings? ◻Yes ◻No
   List names and ages: ____________________________________________________

6. Have you experienced a death in the recent past? (within one year) ◻Yes ◻No
   If yes, who and when did they pass: ________________________________________

7. Please check the box that correlates with your highest level of education.
   ◻High school ◻Associates ◻Bachelors ◻Masters ◻ Doctorate

8. Are you currently employed? ◻Yes ◻No
   a. If yes, what is your current position and place of work?

9. Do you enjoy your work? Is there anything about your work situation that you'd like to change?

10. Do you consider yourself to be spiritual or religious? ◻Yes ◻No
    a. If yes, please describe your faith or belief:

11. What do you consider to be some of your strengths?

12. What do you consider to be some of your weaknesses?

13. Describe your reason(s) for seeking therapy.

14. Describe your goals for therapy.

GENERAL MEDICAL/MENTAL HEALTH INFORMATION

1. Have you previously received any type of mental health services (psychotherapy, psychiatric care, etc.)?
   ◻Yes ◻No
   If yes, please give name(s) of provider(s), treatment dates, and reason(s) for treatment:

2. Are you currently taking any prescription medication? ◻Yes ◻No
   If yes, please name medication(s) and dosage:

3. How would you rate your current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

4. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

5. Do you exercise on a regular basis? □Yes □No
If yes, how many days/week: __________ What types of exercise do you participate in?

6. How would you describe your diet (daily eating habits)? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific changes you'd like to make:

7. Are you currently experiencing or have you experienced sadness, grief, or depression? □Yes □No
If yes, please rate on a scale of 1-10 (with 10 being the most severe): ________
How long? ____________________

8. Are you currently experiencing or have you experienced anxiety, panic, and/or phobia(s)? □Yes □No
If yes, please rate on a scale of 1-10 (with 10 being the most severe): ________
How long? ____________________

9. Do you drink alcohol? □Yes □No
If yes, how many days/week? ______________ How many drinks do you have, on average? ________________

10. How often do you engage in recreational drug use?
□Daily □Weekly □Monthly □Infrequently □Never

11. Please list any significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following.

| Condition | Please Circle | Family Relationship to You |
| --- | --- | --- |
| Addictions (specify): ____________________ | Yes/No | |
| Alcohol/Substance Abuse | Yes/No | |
| Anxiety | Yes/No | |
| Depression | Yes/No | |
| Domestic Violence | Yes/No | |
| Eating Disorders | Yes/No | |
| Obesity | Yes/No | |
| Obsessive Compulsive Behavior | Yes/No | |
| Schizophrenia | Yes/No | |
| Suicide Attempts | Yes/No | |
| Bipolar Disorder | Yes/No | |

Please use the space below to provide any additional/helpful information regarding your family/upbringing:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

# Practice Policies

## Fee Policy

Fees for counseling services are $200 per 50-minute session and are due at the close of each session.  Cancelations must be made 24 hours in advance, otherwise you will be billed for the full session. Other services, such as inpatient visits, significant telephone counseling, etc. are based on the agreed upon per session fee. The rate for legal/court-related services is double the normal per-session fee. I do not accept insurance.

## Confidentiality

Professional ethics and Tennessee state law indicate that that which is discussed in session shall remain confidential. There are three exceptions: (1) if I believe you are at risk of hurting yourself or another person, (2) if I learn that you are abusing children, the elderly, or the disabled, and (3) if I am subpoenaed to court.  In any of those instances, I may break your confidentiality.

## Emergencies

I am available for counseling appointments at selected times throughout the week. If for some reason you are unable to contact me during an emergency, you may obtain assistance by calling the Crisis Help Line at (615) 244-7444 or by going to your local hospital emergency room.

## Benefits and Risks of Counseling

Persons contemplating counseling services should realize they might make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may change employment, begin to feel differently about themselves or others. They may also make changes in their marriages or other significant relationships, such as with parents, friends, children, relatives, etc. While I will assist the client in effecting change, I cannot guarantee specific outcomes. Clients are ultimately responsible for their own growth.

## Credentials

I have a Bachelor of Fine Arts from New York University and a Masters of Arts in Counseling from Trevecca Nazarene University.  I am licensed to practice psychotherapy in TN as a Licensed Professional Counselor (LPC) #3419.

## Informed Consent

By signing this document, I authorize and request Vanessa A. Londino, LPC to provide treatment deemed necessary or desirable for my welfare and therapeutic growth. Additionally, I consent to participate in treatment and understand the limits of confidentiality as well as the benefits and risks of counseling. I understand that I can terminate therapy with Vanessa Londino, LPC at any time.

I have read the Practice Policies section and agree to abide by the terms. ☐Yes☐No

Signature (client): ______________________________ Date: ____________

Signature (therapist): ____________________________ Date: ____________

# Non-secure Communication Policy

## Email Confidentiality Agreement

It is my normal practice to utilize email as a means of communicating with you regarding counseling inquiries and session information. When communicating via email, it is important to remember that confidentiality is limited. By signing below you are saying that you have considered and understand the limitations of confidentiality and agree that you are responsible for keeping your email account private to the extent that you desire for it to be private.

## Text Messaging Confidentiality Agreement

At times, I text message my clients to inform them of upcoming appointments, to change appointment times, or to reschedule appointments. By signing below you are saying that you have considered and understand the limitations of confidentiality and agree that you are responsible for keeping your text messages private to the extent that you desire for them to be private.

I, ________________________________, allow my therapist (Vanessa A. Londino) to email me at this address:

PLEASE PRINT CLEARLY

________________________________________________________________________________

and to text message me at this telephone number:

________________________________________________________________________________

concerning logistical matters. (i.e. appointment times, dates)

Signature ____________________________________________ Date ______________________

## Credit Card Authorization From

Your credit card is kept on file for the following:

1) For your convenience in processing your scheduled session fee;
2) In the unfortunate event that a session fee must be charged due to late cancelation or no show.

This information is also protected as confidential. Please fill out your credit card information and sign, indicating that you understand the 24-hour cancelation policy. Please Note: *there is a $35 processing fee assessed for chargebacks and returned checks.*

CC #: ______________________________________________

Expiration date: ______________ CVV: __________________

Signature __________________________________________ Date ______________________