ENTRY QUESTIONNAIRE
EMILY KERR, LCSW

CONFIDENTIALITY - All information regarding clients, including the fact that they are in treatment, will be kept in confidence. The only exception will be with the patient's written consent, or those exceptions required by law.

Name_____ Date_____

email_____

Address_____ Birthdate_____

_____ Phone home_____
city zip code

cell _____

Employer_____ work_____

Reason for seeking therapy_____

Have you had counseling before? Yes_____ No_____

Date of last physical examination_____ Name of Dr._____

Are you on medication now?_____ Current medication_____

_____ Past medication_____

Do you have any medical problems?_____

Have you ever been hospitalized?_____

For Children and Adolescents:
School you are attending_____ Grade_____

I UNDERSTAND I WILL BE BILLED THE STATED FEE FOR SESSIONS NOT CANCELLED 24 HOURS IN ADVANCE. I agree to this policy.

Date _____ Signature_____

Insurance Co_____ Phone #_____

CLIENT INFORMATION QUESTIONNAIRE

Name_____ Date_____

Circle all that apply:

Nervousness
Shyness
Separation
Drug Use
Prescription Use
Alcohol Use
Anger Issues
Sleep Problems
Relaxation Problems
Legal Matters
Low or High Energy
Loneliness
School Problems
Children/Parenting
Bowel Troubles
Depression Problems
Sexual Problems
Divorce Issues
Self Control
Stress

Headaches
Memory Problems
Insomnia
Inferiority Feelings
Career Choices
Work Problems
Nightmares
Molestation
Appetite/Eating Issues
Parenting
Fears
Anxiety/Worry
Suicidal Thoughts
Harming Others Thoughts
Financial Issues
Cutting Yourself
Hurting Yourself
Pulling your Hair
Bedwetting
Friends

Unhappiness
Tiredness
Ambition
Attention
Concentration
Making Decisions
Health/ Medical
Marital/Couple
Stomach Problems
My Thoughts
Relationships
Sexual Identity
Sadness
Loss of Interest
Lack of Energy
Problems with Relationships

Other_____