

MINDBODY THERAPY & HEALING, INC.
Suzanne Nixon, EdD, LPC, LMFT

INDIVIDUAL QUESTIONNAIRE: ADULT

Name _____ Date _____

Address _____

Phone (H) _____ (W) _____ (C) _____

Best number to contact you at _____ May I leave a voice mail? _____

Email _____

Birth date _____ Age _____ Social Security # _____

Place of Employment _____

Position _____

Status: ___ Single ___ Married ___ In Partnership (If in relationship):

Duration of current relationship _____ Previous Marriages? ___ Yes ___ No

Children? ___ Yes ___ No How many? _____ Ages _____

Where do they live? _____

Other persons/pets living with you _____

Who referred you? _____ May I thank them? _____

Emergency Contact _____ Phone _____

Relationship to you _____

Are you presently under the care of a physician? _____ If so for what?

Are you currently on any prescription medications? _____ If so, please list:

What symptoms are you currently experiencing, or what issues are you currently dealing with? (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> unhappiness | <input type="checkbox"/> parenting issues | <input type="checkbox"/> self esteem |
| <input type="checkbox"/> depression | <input type="checkbox"/> family issues | <input type="checkbox"/> work issues |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> relationship issues | <input type="checkbox"/> phobias |
| <input type="checkbox"/> communication issues | <input type="checkbox"/> sexuality | <input type="checkbox"/> life transitions |
| <input type="checkbox"/> financial issues | <input type="checkbox"/> addiction | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> difficulty trusting | <input type="checkbox"/> eating issues | <input type="checkbox"/> irritability |
| <input type="checkbox"/> difficulty with anger | <input type="checkbox"/> sadness | |

other _____

Do you currently, or in the past, have you had any addictive behaviors? (eating, gambling, money, alcohol, drugs, sex, pornography) If yes, explain:

In the past year have you had any self harm thoughts/actions? _____

In the past year have you had any suicidal thoughts/attempts? _____

Are you currently, or have you ever been, in an abusive relationship? _____

If yes, explain _____

Other concerns or issues? Please explain:

Which symptoms/issues are of most concern to you today?

Have you received professional therapeutic help prior to coming here today? If so, when, and for how long? Was it helpful?

