RUTH KRUMBHAAR, MFT
WELLTHERAPYSF.COM
399 Laurel Street #11 San Francisco, CA 94118
415.999.7277 lic #53637

QUESTIONNAIRE FOR ADULT CLIENTS

Please complete this questionnaire as fully as possible. If you need additional space, please use the bottom of the form.

Today's Date ___/___/___

Name

Date of birth Age

Age

Address

Phone Email

Referred By:

Occupation/Employer

Emergency Contact

Education

School	Graduated (Y/N)	Degree	Field of Study

Religious Affiliation:

Recreation (some typical activities):

Marital status:

Previously Married?

Number of times/duration

Please explain

Please state the reason for which you are seeking treatment.

When and how did the issues(s) begin and what have you done help yourself?

Please list each person who resides with you (please indicate name/relationship/age):

Do you have children who do not live with you?
If YES, please list with name and age:

Have there been deaths in your family or among your friends?
If YES, please list (who/when):

Have you moved recently?
If YES, when:

Have you moved often?
If YES, please explain

Do you plan a move in the near future?
If YES, please explain

Work History (past 10 years)

	Employer	Job Title	Date Start	Date End	Reason for Leaving
1.					
2.					
3.					
4.					
5.					

Family History

Please provide information on your mother, father, siblings, and step or half-family members.

Name and Relationship	Age	Health Status	Occupation	Where Resides	Frequency of Contact

Have you ever been separated from family members for a prolonged period?

Were there separations from your family or either parent when you were a child (e.g., father hospitalized for 4 weeks when you were 6)?

If YES, please explain.

Is there any history of mental, emotional, or psychiatric problems in your family?

If YES, please explain.

Medical History

Please list any medications taken . . .

On a Regular Basis Now	Previously

Please list any previous psychotherapy (approximate dates and reason for seeking help).

Please provide a history of each pregnancy, miscarriage or abortion.

Please list any chronic health conditions (e.g., asthma, high blood pressure).

Please list any serious accidents or illnesses for which hospitalization was not required.

What is your current state of health?

Symptoms and Behaviors Checklist

Please indicate the severity of the listed symptoms, if known, for the past year.

SYMPTOM	SEVERITY			
	None	Mild	Moderate	Severe
Depression				
Tearfulness				
Feeling lonely				
Feeling sad				
Withdrawn				
Spending more time alone				
Moody				
Avoiding friends				
Concerned about injury				
Eating more				
Eating less				
Weight change				
More exercise				
Decreased interest in sex				
Decreased interest in usual activities				
Tired				
Sleeping more				
Sleeping less				
Waking during the night				
Waking early in the morning				
Sleepwalking				

SYMPTOM	SEVERITY			
	None	Mild	Moderate	Severe
Nightmares/Bad dreams				
Headaches				
Careless about dress/hygiene				
Having trouble concentrating				
Confused				
Distractable				
Impulsive				
Disorganized				
Hearing things others don't hear				
Seeing things others don't see				
Trouble following directions				
Perfectionistic				
Anxious				
Worrying				
Feeling panicky				
Obsessive/ritualistic behaviors				
Critical of others				
Have few friends				
Low self-esteem				
Disappointed in appearance				
Disappointed in achievements				
Disappointed in social life				
Legal problems				
Problems at work				
Problems in daily life				
Arguing				
Destroying/damaging property				
Irritable				
Angry				
Easily frustrated				
Giving away belongings				
Wishes to be dead/Suicidal thoughts				
Suicidal or homicidal thoughts				