Inga-Britt Ostrom, MS, MFT

Marriage Family Therapist

3180 University Ave., Suite 210

San Diego, California 92104

Phone 619-972-2551

CLIENT QUESTIONNAIRE

Client's Name ______________________________ Date of Birth ______________________________

Spouse's or Parent's Name ______________________ Date of Birth ______________________________

Address______________________________ City ____________ Zip Code ____________________

Phone (Home)___________________________ Work ____________ Cell ____________________

Occupation_____________________________ Social Security Number ______________________

Married ______How Long ________How Many Times _______ Single _____ Widowed _______ Divorced ___________

Spouse's Work Phone ______________________ Health Insurance __________________________

Referred By_____________________________ Church/Religious Affiliation _____________________

Members of Household/Family Members	D.O.B.	Relationship
______________________________	__________	______________________________
______________________________	__________	______________________________
______________________________	__________	______________________________
______________________________	__________	______________________________
______________________________	__________	______________________________

General Health ____

Name of Physician ______________________ Medications _________________________________

Spouse or parent's general health ____

Are you or your spouse currently under the care of a psychiatrist, psycologist or counselor? ______________________

If yes, please specify name and address ____

Have you, your child or your spouse received professional counseling or psychiatrist care in the past? _______________

If yes, please indicate name and address ____

Have you, your child or your spouse ever been hospitalized for an emotional or psychological reason? _______________

If yes, please indicate when are where ____

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List Use of Drugs and/or Alchohol (Past and Present)

Drugs How Often First Date of Use Last Date of Use

____

____

Alcohol How Often First Date of Use Last Date of Use

____

____

Tobacco How Often First Date of Use Last Date of Use

____

Ever had suicidal thoughts? ____

Any suicidal attempts? ____

Were you sexually molested? __________________________ By whom? ____________________

Were you every physically abused?_______________________ By whom? ____________________

Were you ever emotionally abused? ______________________ By whom? ____________________

Client Signature ___________________________________ Date ________________________

Spouse's/Parent's Signature ____________________________ Date ________________________

Primary Concern

____

____

____

Counseling Goals

____

____

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