NEW CLIENT Questionnaire

Full name: _____Preferred name / Nickname: _____

Age:_____Birthdate: _____Social Security Number: _____

Address: _____ _____

E-mail: _____ Do you have a Safe-Mail Email Address?: ___ , if so please provide _____

Cell Phone: _____

Home Phone: _____

How did you find out about Dr. Masha Godkin, Psy.D, MFT?_____

Occupation: _____

Marital / Relationship Status: _____

Any children? (Names, ages): _____

Your highest level of education: _____

Religion / Spiritual beliefs: _____

Any current medical conditions?_____

Any medications that you currently take?_____ _____

Have you ever been hospitalized (for medical, mental or substance use issues) and when: _____

_____

Have you had previous online therapy / counseling? When, for how long, and what was the outcome? _____

_____

Have you had any involvement with the legal / criminal justice system? When and why?

_____

_____

_____

Do you currently smoke? _____ Do you drink alcohol and how much?

_____

Do you currently use illicit drugs, or have you in the past? List:

_____

_____

_____

Have you ever struggled with substance abuse or dependence?

_____

Have you ever strongly considered or attempted suicide? When?

_____

_____

_____

Have you ever been violent with strangers or people close to you?

_____

_____

_____

What stressors in your life currently bother you the most? Please list:

_____

_____

_____

What currently gives you the most joy in your life?

_____

_____

_____

What are your top strengths as an individual?

_____

_____

_____

What are your most important hopes and goals?

_____

_____

_____

Finally, and most importantly, what do you hope to achieve/address in counseling?

_____

_____

_____

Is there anything else you would like your clinician to know?

_____

_____

_____

Choose the service you prefer: ___Email Counseling, ___Chat Therapy, ____ Telephone Counseling, ____Skype Video Counseling

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Client Signature: _____ Date: _____