SONYA L. FONTAINE LPC, PLLC
CLIENT INFORMATION QUESTIONNAIRE

Date: _____

Name: _____ SS#_____ Sex: ☐ Male ☐Female Age:_____ Date of Birth:_____
First Initial Last

Address: _____
Street Apt # City State Zip

Telephone Number: Home (_____) _____ Work (_____) _____ Cell (_____) _____

E-mail: _____ Permission to contact by email: ☐Yes ☐No

Do you attend a church: ☐Yes ☐No Church Attended _____ Member: ☐Yes ☐No How regularly _____

Marital Status (Check one): ☐Single ☐Married ☐Remarried ☐Separated ☐Divorced ☐Widowed

Employer: _____ Occupation: _____ Employer Phone: (_____) _____

Employer Address: _____
Street City State Zip

Permission to contact you at work: ☐Yes ☐No Permission to leave a message on your cell phone: ☐Yes ☐No

Highest Level of Education: ☐Grade School ☐High School ☐Technical Degree ☐Bachelor's Degree ☐Master's Degree ☐Advanced Degree

Spouse's Name: _____ SS#_____ Sex: ☐Male ☐Female Age:_____ Date of Birth:_____
First Initial Last

Does your spouse attend a church: ☐Yes ☐No Church Attended _____ Member: ☐Yes ☐No How regularly _____

Employer: _____ Occupation: _____ Employer Phone: (_____) _____

Employer Address: _____
Street City State Zip

Permission to contact spouse for scheduling appointments: ☐Yes ☐No

Highest Level of Education: ☐Grade School ☐High School ☐Technical Degree ☐Bachelor's Degree ☐Master's Degree ☐Advanced Degree

Number of marriages: You _____ Spouse _____

Child's Name	Age	Child's Name	Age

Source of Referral: ☐Friend _____ ☐Physician _____

☐Minister/Church _____ ☐Other(List) _____

Have you ever consulted a professional counselor or psychiatrist?: ☐Yes ☐No Hospitalized: ☐Yes ☐No

Date _____ Problem Addressed _____ Counselor _____

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Health information:
Primary Care Physician: _____ Phone: _____ Last Visit: _____

1. What medications are you currently taking and the reason:

_____

2. Please list any surgeries or major illnesses you have had:

_____

3. Do you have a history or are currently experiencing of any of the following: (circle all that apply)

Depression	Unrealistic fears	Death of a parent	Obsessive-compulsive behaviors
Decreased ability to sleep	Anger outbursts	Death of a spouse	Spousal abuse
Decreased appetite	Mood swings	Death of a child	Hyperactivity
Increased appetite	Physical abuse	Forgetfulness	Pornography
Increase in sleeping	Sexual abuse	Divorce	Hearing voices others cannot hear
Anxiety	Emotional abuse	Separation with spouse	Same sex attraction
Panic attacks	Addiction to alcohol or drugs	Irritability	Seeing things others cannot
Addiction (other) _____			

Suicidal Thoughts: ☐current ☐past frequency: _____ when: _____ Suicide Attempt – date: _____ Hospitalized ☐Yes ☐No

Briefly describe your reason for seeking therapy?

_____

What have you attempted to do to treat this problem? What has worked and has not worked?

_____

_____

How will you know when therapy has been successful?

_____

_____

_____

Please provide any additional information, which you feel pertinent for therapy?

_____

_____

Would you like Sonya to pray with you in session? ☐Yes ☐No

Our goal is to best meet your emotional needs in a confidential, respectful and God-centered way.
Please feel free to discuss this or any other issue with us.
Sonya L. Fontaine L.P.C., PLLC