Viva Client Information Questionnaire

The information you provide in this questionnaire will be helpful in planning services for you as a Viva Center client. Please answer each item carefully and ask for clarification if you do not understand an item. Answer only those items that pertain to you.

Full Name ____ Date ______________

Address ____

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Telephone(s) ___________________ / ______________________ / ________________
(Home) (Work) (Other)

Email Address: ____

Date of Birth ____________ Partnership Status ________________ # of Children ____

Adoption status __________________ Family members adoption status _____________

How were you referred to The Viva Center? ___________________________________

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Please list the primary concerns that led you to seek help:

What are your goals for treatment at The Viva Center as you know them now?

List any major illnesses, hospitalizations, surgeries, injuries and current major health problems as well as the date of your last examination by a physician:
Exam Date: __/__/__

List any medications that you are now taking and the contact information of the doctor

prescribing them: ____

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Have you ever received psychiatric help or counseling of any kind? Yes/No
If "yes," please state when, where and with whom:

Please check all of the following items that concern or pertain to you:

__ Nervousness	__ Shyness	__ Depression	__ Fears
__ Anxiety	__ Stomach Trouble	__ Concentration	__ Self-control
__ Sexual Abuse	__ Career Choices	__ Fatigue	__ Relaxation
__ Alcohol Use	__ Drug Use	__ Trouble Sleeping	__ Sadness
__ Sleeping A Lot	__ Nightmares	__ Flashbacks	__ Appetite
__ Suicidal Thoughts	__ Panic Attacks	__ Ambition	__ Inferiority Feelings
__ Relationships	__ Sexuality	__ Dissatisfaction	__ Marriage
__ Separation	__ Hyperactivity	__ Mood Swings	__ Being a Parent
__ Forgetfulness	__ Frequent Lying	__ Money Mgmnt	__ Aggressive
__ Perfectionism	__ Friends	__ Headaches	__ Temper
__ Making Decisions	__ Energy	__ Sexual Problems	__ Divorce
__ Legal Matters	__ Anger	__ Loneliness	__ Physical Abuse

__ Problems in coping with death (specify who died: ___________________________)

__ Problems in coping with medical illness (specify illness: _____________________)

Please add any additional comments you feel would be useful. Please include any family information that you consider problematic such as substance abuse, mental illness, violence, inappropriate touching, etc.:

Please list members of your family and all others in your home:

Name Birth Date Relationship

Work History:

Occupation: ______________________________________ How long? ____________

Satisfied in present employment? (Yes / No) Highest education level completed? _____

Please add anything you feel is relevant, or that would help you to be better understood:

Sexual History:

What problems or concerns have you experienced with your sexuality?

Overall, how would you describe your sex life?

What traumatic sexual experiences have you had?

Chemical Usage History:

Describe your use of drugs, including alcohol and prescription medications (how much, how often, when, with whom, etc.):

Have there been any undesirable results from your chemical use (poor school/job performance, physical problems, relationship stress, DWIs, etc)? Explain.

Has anyone ever expressed concern regarding your chemical use? Explain.

Are you concerned about any other compulsive or addictive behavior? Describe. (Eating, shopping, sexual behavior, cleanliness, repetitive actions, working, etc.)

How important is spirituality in your life? (please circle)

Not Somewhat Very

If spirituality is a part of your life, in what way? Do you have a regular spiritual practice? Please elaborate.

Please add any information that you feel may be useful:

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Thank you for completing this questionnaire.

____ _________________
Your signature Date

Insurance Company ____