

Today's Date \_\_\_\_\_

# The Life Empowerment Center

2111 Dickson Drive, Suite 14  
Austin, Texas 78704

Phone (512) 804-2343  
Fax (512) 804-2300

## Client Information

Client Name \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ Employer \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Grade Completed \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ email Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Emergency Contact \_\_\_\_\_

Referred By \_\_\_\_\_ Contact's Phone \_\_\_\_\_

Responsible Party \_\_\_\_\_ Primary Physician \_\_\_\_\_

Relationship \_\_\_\_\_

Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

List other individuals living in your home: Name, Age, and Relationship: \_\_\_\_\_

List the name of all medications taken regularly and explain why you take them: \_\_\_\_\_

Describe any significant health problems you have at this time: \_\_\_\_\_

Describe any prior psychotherapy treatment and hospitalizations for psychological reasons: \_\_\_\_\_

Describe your reason(s) for seeking assistance at this time: \_\_\_\_\_

List any other information that you believe would be important for me to know. \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

*This information is on our website for your review.*

**Please read, sign and print this page, and bring with you to your initial appt.**

**The Life Empowerment Center  
James Ochoa, LPC, Inc.**

**NOTICE OF PRIVACY PRACTICES**

*You will NOT be penalized for filing a complaint.*

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Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I acknowledge that the Therapist provided me with a written copy of his Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Personal Representative Signature (if applicable)

\_\_\_\_\_  
Relationship to Patient

## New Client Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

### CURRENT ISSUES

1. What led you to seek an evaluation at this time?
  
  
  
  
  
  
  
  
  
  
2. What are your greatest concerns about your behavior?
  
  
  
  
  
  
  
  
  
  
3. **Current Life Stressors** (examples: relationships, job, school, finances, children):

### EARLY EDUCATION

1. How old were you when you first noticed these problems? (circle one)  
a. 0 – 7 years    b. 8 – 12 years    c. 13 – 15 years    d. 16 – 21 years    e. 22+ years
  
2. Have you sought treatment for these problems before?  
a. Yes            b. No  
  
If yes, when and where did you seek treatment?
  
  
  
3. If yes, what was the outcome of the treatment you sought?

The following are some childhood symptoms of ADHD. Please indicate if these were more of a problem for you than for other people in your peer group.

	Symptom	Yes No	Now is it the Same / Better Or Worse?	Comments
A	Fidgetiness or feeling restless			
B	Difficulty remaining satisfied			
C	Being easily distracted			
D	Difficulty waiting your turn			
E	Blurting out answers before the question is completed			
F	Difficulty following through on or completing tasks			
G	Sustaining attention in tasks			
H	Frequently shifting from one task to another			
I	Difficulty doing tasks alone			
J	Talking too much			
K	Interrupting or intruding on others			
L	Not listening to others			
M	Losing important things or forgetting a lot			
N	Engaging in physically daring activities			
O	Always on the go, as if driven by a motor			
P	Making decisions too quickly or acting too quickly			
Q	Impatient			

5. Did your parents ever take you to see anyone about these problems when you were a child or adolescent?

- a. Yes                      b. No

6. Did you parents say that you were difficult to control as a child?

- a. Yes                      b. No

If yes, at what ages did your parents say that you were difficult to control as a child?

- a. 0 – 7 years      b. 8 – 12 years      c. 13 – 15 years      d. 16 – 21 years      e. 22+ years



If yes, please describe below:

Grade in School	How Many Fights Did You Start?	How Many Fights Did Others Start?	Did You Use A Weapon?

18. Please provide information about the number of times you ran away from home, if any:

Age When You Ran Away?	Number of Times You Ran Away	Number of Nights You Stayed Away	Longest Period of Time You Stayed Away

### DEVELOPMENTAL HISTORY

1. Do you know if your mother had any trouble when she was pregnant with you?

- a. Yes          b. No          c. Not sure

If yes, please describe.

2. Do you know if your mother had any trouble when she delivered you?

- a. Yes          b. No          c. Not sure

If yes, please describe.

3. Did you learn to sit up, walk and talk on time?

- a. Yes          b. No

If no, please explain.

4. Did you have any childhood illnesses?

- a. Yes          b. No

If yes, please describe.

5. Did you have normal relationships with your peers when you were a child?

- a. Yes          b. No

If no, please explain.

6. Do you remember any family folklore stories or stories about you as you were growing up?  
If yes, please describe:
  
7. Did you have any nicknames while growing up? If yes, please explain:

## **EMOTIONAL PSYCHIATRIC HISTORY**

### **Alcohol/Drug Use**

1. How much alcohol do you drink in a week?  
a. None      b. 1 to 2 drinks      c. 3 to 4 drinks      d. 5 to 10 drinks      e. 10 or more drinks
  
2. Did you ever drink more heavily than you do now?  
a. Yes      b. No  
If yes, please describe.
  
3. Have you ever used any drugs recreationally?  
a. Yes      b. No      If yes, what types and how often?
  
4. Have you ever misused or abused any prescription drugs?  
a. Yes      b. No  
If yes, please describe.
  
5. Have you ever seen a counselor or psychiatrist before?  
a. Yes      b. No  
If yes, please explain.
  
6. Have you ever been hospitalized for a psychological or psychiatric problem?  
a. Yes      b. No  
If yes, please provide details.
  
7. How would you describe your mood most of the time?

- a. Normal and Fairly Stable
- b. Anxious or Nervous
- c. Depressed or Sad
- c. Fairly Unstable
- d. Frequently Changing
- e. Other (please describe)

8. Have you ever had problems with depression?

- a. Yes
- b. No

If yes, please explain:

9. Have you ever had problems with anxiety?

- a. Yes
- b. No

If yes, please explain:

10. Describe any problems you have with your temper.

11. Have you ever lost your temper enough to hurt anyone or damage any property?

- a. Yes
- b. No

If yes, please describe:

12. Do other people complain about your temper?

- a. Yes
- b. No

If yes, please explain.

13. Do you ever have problems with your sleep?

- a. Yes
- b. No

If yes, please describe.

14. Have you ever had problems with your weight?

- a. Yes
- b. No

If yes, please describe.

15. Have you ever used any diet products or preparations?

- a. Yes            b. No

If yes, please describe.

16. Have you experienced an overt trauma during your lifetime (ie., near death experience, abuse, loss of a loved one, fear for your life, etc?)

**MEDICAL HISTORY**

1. Do you have any current medical problems?

- a. Yes            b. No

2. Have you ever been hospitalized for medical problems?

- a. Yes            b. No

If yes, please provide details.

3. Have you ever lost consciousness?

- a. Yes            b. No

If yes, please tell all you remember about the incident.

4. Please, provide information about your medical history.

Medical Problem	Have <b>You</b> Had this Problem?		When? Please Explain	Has a <b>Family Member</b> Had this Problem?		Who? When? Please Explain.
	Yes	No		Yes	No	
Heart Problems						
Liver Disease						
Glaucoma						
Seizures						
Stroke (CVA)						
Neurological Problems						
High Blood Pressure						
Chest Pain						
Shortness of Breath						

Head Injury				
Encephalitis				
Brain Infection				
Tics or Unusual Body Movements				
Vocal Tics or Unusual Noises				
Tourette's Syndrome				
Thyroid Gland Problems				
Weight Problems				
Sleep Problems				
Allergy Problems				
Other				

5. Are you currently taking any medications?

- a. Yes            b. No

Name of Medication	Dosage	Name of Doctor	Reason for Taking

6. Are you allergic to any medications?

- a. Yes            b. No

If yes, please describe.

7. Are you sexually active?

- a. Yes            b. No

8. Are you (or your partner) trying to get pregnant now?

- a. Yes            b. No

9. Do you (or your partner) intend to get pregnant within the next five years?

- a. Yes            b. No

10. Are you (or your partner) currently nursing a baby?

- a. Yes            b. No

11. Have you ever had any seizure like activity?  
a. Yes            b. No
12. Have you ever had any periods of spaciness or confusion?  
a. Yes            b. No
13. Present height: \_\_\_\_\_ Present weight: \_\_\_\_\_

**FAMILY HISTORY**

**Natural Mother's History:** Age \_\_\_\_\_ Outside Work \_\_\_\_\_

School: Highest Grade Completed: \_\_\_\_\_

Learning Problems (Specify): \_\_\_\_\_

Behavior Problems (Specify): \_\_\_\_\_

Marriage(s): \_\_\_\_\_

Medical Problems (Specify): \_\_\_\_\_

Childhood Atmosphere (family position, abuse, illnesses, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has mother ever sought psychiatric treatment? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, for what purpose? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Mother's alcohol/drug use history: \_\_\_\_\_

\_\_\_\_\_

Have any of mother's blood relatives ever had any learning problems or psychiatric problems including such things as, alcohol/drug abuse, depression, anxiety, suicide attempts, and psychiatric hospitalizations? (Please specify)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Natural Father's History:** Age \_\_\_\_\_ Outside Work \_\_\_\_\_

School: Highest Grade Completed: \_\_\_\_\_

Learning Problems (Specify): \_\_\_\_\_

Behavior Problems (Specify): \_\_\_\_\_

Marriage(s): \_\_\_\_\_

Medical Problems (Specify): \_\_\_\_\_

Childhood Atmosphere (family position, abuse, illnesses, etc.) \_\_\_\_\_

\_\_\_\_\_

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Has father ever sought psychiatric treatment? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, for what purpose? \_\_\_\_\_

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Father's alcohol/drug use history: \_\_\_\_\_

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Have any of father's blood relatives ever had any learning problems or psychiatric problems including such things as, alcohol/drug abuse, depression, anxiety, suicide attempts, and psychiatric hospitalizations? (Please specify)

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**Siblings (Names, ages, problems, strengths, relationship to patient):** \_\_\_\_\_

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**Children (Names, ages, problems, strengths):** \_\_\_\_\_

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**SOCIAL HISTORY**

1. Do you smoke cigarettes?

- a. Yes            b. No

If yes, how many packs a day?

2. Have you ever smoked cigarettes?

- a. Yes            b. No

If yes, how long ago did you quit?

3. How much coffee, tea and/or sodas do you drink that contain caffeine?

- a. None

- b. 1 to 2 cups a day
- c. 3 to 4 cups a day
- d. 5 to 6 cups a day
- e. 7 to 8 cups a day
- f. 9 or more cups a day

4. Did you ever get into trouble for stealing or damaging property as a child or a teenager?

- a. Yes
- b. No

5. Have you ever been in trouble with the law?

- a. Yes
- b. No

6. Do you have a driver's license?

- a. Yes
- b. No

If no, why not?

7. How many traffic tickets (not parking tickets) have you received?

- a. None
- b. One
- c. Two or Three
- d. Four or More

8. How many car accidents have you been in when you were the driver?

- a. None
- b. One
- c. Two or Three
- d. Four or More

9. Are you currently married?

- a. Yes
- b. No

If yes, how long?

10. If yes, what is your current level of satisfaction in your marriage?

- 1
  - 2
  - 3
  - 4
  - 5
  - 6
  - 7
  - 8
  - 9
  - 10
- Very Distraught Things are great

11. Have you had previous marriages?

- a. Yes
- b. No

If yes, please provide details.

12. Do you have any children?

- a. Yes
- b. No

If yes, please provide names and ages.

13. If you are not married, are you currently in an intimate relationship?

- a. Yes
- b. No

If yes, how long have you been in this relationship?

14. How many intimate relationships have you had that have lasted for more than 3 months?

- a. None
- b. 1 or 2
- c. 3 or 4
- d. 5 or more

15. Have you ever served in the military?

- a. Yes
- b. No

If yes, please provide details (highest rank, special honors, duties, discharge status, etc.)

16. Please list your job history beginning with your most current position.

Job Title	Company Name	How Long	Reason for Leaving

Cultural/Ethnic Background: \_\_\_\_\_

Describe Your Relationships with Friends: \_\_\_\_\_

Describe Yourself: \_\_\_\_\_

What are your goals in seeking this consultation? What do you hope to gain? \_\_\_\_\_