DR. JULIE LOPEZ
Live Empowered

Client Information Questionnaire

Identifying Information
Please list your full name: _____

Please indicate either the phonetic spelling of your name OR a familiar word that rhymes with your name, for example, Mario Gonzalez: MAH-ree-oh gon-SAH-les; Anne Barowski: Anne Ba-ROFF-skee; Lisa Lamagna: Lee-sah / sounds like “lasagna”:

My pronouns are: _____

Alternatively, you may choose from the following options (please check as many that apply):

- ❏ He/him/his
- ❏ She/her/hers
- ❏ They/them/theirs
- ❏ Ze/hir
- ❏ Choose Not to Disclose

Please list your age: _____ My current gender identity is: _____

Alternatively, you may choose from the following options (please check as many that apply):

- ❏ Male
- ❏ Female
- ❏ Transgender Male/Transgender Man/ Female-to-Male (FTM)
- ❏ Transgender Female/Transgender Woman/Male-to-Female (MTF)
- ❏ Genderqueer – neither exclusively male nor female
- ❏ Non-binary / Gender Non-Conforming
- ❏ Choose Not to Disclose

My racial and / or ethnic identity is: _____

Alternatively, you may choose from the following options (please check as many that apply):

- ❏ Alaskan Native
- ❏ American Indian
- ❏ East Asian American
- ❏ Black / African American / Afro-Caribbean
- ❏ Hispanic / Latino / Spanish
- ❏ Middle Eastern / North African
- ❏ Native Hawaiian / Other Pacific Islander
- ❏ White / Caucasian
- ❏ Choose Not to Disclose

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How did you hear about Dr. Julie's Intensives?:

Presenting Issues
Please list the primary concerns that led you to Dr. Julie and her Internsives?

What are your goals for treatment as you know them now?:

Current Symptoms (check all that apply):

- ❏ Anger
- ❏ Concentration
- ❏ Frequent Lying
- ❏ Hyperactivity
- ❏ Impulsivity
- ❏ Irritability
- ❏ Mood Swings
- ❏ Obsessive Thoughts
- ❏ Racing Thoughts
- ❏ Avoidance
- ❏ Depression
- ❏ Fatigue
- ❏ Feelings of Inferiority
- ❏ Grief
- ❏ Guilt
- ❏ Libido Changes
- ❏ Loneliness
- ❏ Sadness
- ❏ Self Harm
- ❏ Sleep Changes
- ❏ Suicide Attempts
- ❏ Suicidal Thoughts
- ❏ Appetite Issues
- ❏ Body Image
- ❏ Compulsive Eating
- ❏ Anxiety
- ❏ Chronic Pain
- ❏ Dissociation
- ❏ Panic Attacks
- ❏ Fear
- ❏ Headaches
- ❏ Nervousness
- ❏ Overwhelm
- ❏ Relaxation
- ❏ Stomach Troubles
- ❏ Flashbacks
- ❏ Hallucinations
- ❏ Nightmares
- ❏ Intimacy Issues
- ❏ Sexual Identity
- ❏ Sexuality
- ❏ Alcohol Use
- ❏ Risky Activity
- ❏ Drug Use
- ❏ Emotional Abuse
- ❏ Physical Abuse
- ❏ Sexual Abuse
- ❏ Trauma
- ❏ Ambition
- ❏ Career Satisfaction
- ❏ Coping With Medical Illness
- ❏ Legal Issues
- ❏ Making Decisions
- ❏ Money Management
- ❏ Perfectionism
- ❏ Friends
- ❏ Parenting
- ❏ Relationships
- ❏ Separation/Divorce

Medical History
Please provide the name and contact information for your primary care physician.

Please indicate the date (approximately) of your last examination by your primary care physician.

List any present or chronic illnesses, previous hospitalizations, surgeries, and/or injuries.

List any medications you are currently taking (include dosage and prescribing physician if known)?

Have you ever received psychiatric help or counseling of any kind?:

If "Yes", please state when, where and with whom

Household
Relationship Status:

Please list household members' names, ages, and any concerns you may have.:

Family History
Who raised you? Where did you grown up?:

Siblings and their ages:

Family member medical conditions:

Family member mental conditions:

Are you a member of the adoption constellation? (Check all that may apply)

- ❏ Yes
- ❏ No
- ❏ Adopted Person
- ❏ Birth parent
- ❏ Adoptive parent
- ❏ Other

If other, you may explain here:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Education
What is your highest education level completed?:

Occupation
What is your current occupation?:

Employment Status:

How long have you been working in your current position?:

Are you satisfied in your present employment?:

If "No", in what ways are you dissatisfied?:

Sexual History
My sexual orientation is:

Alternatively, you may choose from the following options (please check as many that apply):

- ❏ Asexual
- ❏ Bisexual
- ❏ Gay
- ❏ Heterosexual
- ❏ Lesbian
- ❏ Pansexual
- ❏ Queer
- ❏ Questioning
- ❏ Choose Not to Disclose

Have you had any problems or concerns with your sexuality?:

Overall, how would you describe your sex life?:

Have you had any traumatic or non-consensual sexual experiences?:

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Substance Use History
Have you ever used drugs or alcohol? If yes, list frequency/dates of use.:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Have you ever abused prescription drugs? If yes, which ones?:

Have there been any undesirable results from your chemical use (poor school/job performance, physical problems, relationship stress, DWIs, arrests, etc?) If yes, please explain.:

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

Self Care
What resources (internal and external) do you use when feeling overwhelmed?:

Which individuals do you most frequently reach out to for social and emotional support?:

Spirituality
How important is spirituality in your life?:

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

Additional
Anything else you want the therapist to know?: