PALO ALTO UNIVERSITY
Engaging Minds, Improving Lives

THE GRONOWSKI CENTER
A COMMUNITY CLINIC FOR PSYCHOLOGICAL SERVICES

Client Questionnaire

Welcome to The Gronowski Center. Please complete the following information before your first appointment. Please take the time to fill out this form carefully. This will help us understand the problems for which you are seeking help and make sure that you receive the best possible treatment.

Name: _____Date of Birth: _____

Address: _____

Phone: Home ( ) Cell ( ) Work ( )

May I call you at home? ☐Yes ☐No Cell? ☐Yes ☐No Work? ☐Yes ☐No

May I leave a voice message on:
your home number? ☐Yes ☐No Voice message: Cell? ☐Yes ☐No Voice message: Work? ☐Yes ☐No

Can I mail information to you at your home address? ☐Yes ☐No

Demographic information

Gender: ☐ Male ☐ Female ☐ Transgender Male/FTM ☐ Transgender Female/MTF
☐ Genderqueer/ Both man and a woman/Neither man nor a woman ☐ Prefer not to answer

Ethnicity (please check):
- ☐ African American
- ☐ Asian American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American
- ☐ Pacific Islander
- ☐ Other (please specify)

Marital Status:
- ☐ Never Married
- ☐ Married
- ☐ Living Together, Not Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Sexual Orientation: (Optional)
- ☐ Heterosexual
- ☐ Gay/Lesbian
- ☐ Bisexual
- ☐ Other

Education: (Highest grade/degree completed) _____

Employment History

Currently employed? ☐ Yes ☐ No

If employed, Current Employer/Company: _____

Current Occupation: _____

In general, how important are your religious or spiritual beliefs in your day-to-day life?

☐ Not at all important ☐ Somewhat important ☐ Fairly important ☐ Very important

What is your religion or religious affiliation, if any?

☐ Agnostic
☐ Atheism/No religion
☐ Bahá'í
☐ Buddhism
☐ Christianity:
_____
☐ Confucianism
☐ Hinduism
☐ Islam
☐ Jainism
☐ Judaism
☐ Shinto
☐ Sikhism
☐ Taoism
☐ Other. Please specify:
_____
☐ Prefer not to answer
☐ Spiritual, not religious

Please describe (briefly) the reason(s) you are seeking therapy at this time?

_____

_____

_____

_____

_____

_____

_____

Please Describe Your Current Living Situation (e.g., living alone, roommate, family, etc.) :

_____

Family members including all dependent children [if applicable]	Age	Gender	Living with you?	Are you the legal guardian? [Yes, No, Not Applicable (NA)]

Psychiatric/Mental Health History

Are you ***currently*** being treated by a psychiatrist or other mental health practitioner? ☐ Yes ☐ No

Have you ***ever been*** treated by a psychiatrist or mental health practitioner? ☐ Yes ☐ No

If yes to either question, please complete:

Name of Practitioner	Date(s) Seen	Reason(s) for Treatment	Was it helpful?

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Have you ever been hospitalized for an emotional or psychiatric reason? ☐Yes ☐No

If yes, please list below

Dates	Name of Hospital	Reason for Hospitalization	Was it Helpful?

Are you currently taking any medication for psychiatric or psychological reasons? ☐Yes ☐No

If yes, please list below:

Condition	Medication	Dose (mg)	Date Started	Effective?	Name of Doctor prescribing med

Have you ever tried to hurt yourself? ☐Yes ☐No OR Made a suicide attempt? ☐Yes ☐No

If yes to either question please list below

Dates	What you did to hurt yourself or describe your suicide attempt	Were you hospitalized?

Are you currently having any thoughts of suicide? ☐ Yes ☐ No

Have you had thoughts of suicide in the past month? ☐Yes ☐ No

Have you had thoughts of suicide in the past year? ☐ Yes ☐ No

Medical History

Current Primary Care Physician:

Name: _____Phone #: _____Date of last visit/Physical exam? _____

Address:_____

Please list any current medical problems:

_____

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Current (non-psychiatric) Medications (please include prescription and over-the-counter medications)

Condition	Medication	Dose (mg)	Date Started	Effective?

Do you have any ***Current*** problems with drugs or alcohol? ☐ **Yes** ☐ **No**

If yes, please give details, such as name/type of substance(s) used, number of times per week used, and length of time you have been using substance:

_____

_____

_____

Do you have any ***Past*** problems with drugs or alcohol? ☐ **Yes** ☐ **No**

If yes, please describe:

_____

_____

_____

_____

Have you ever received treatment for a drug or alcohol related problem? ☐ **Yes** ☐ **No**

If yes, please list below

Dates (Mo/Yr)	What type of substances were you using?	Type of Treatment (hospital, outpatient program, AA, NA, etc.)

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Have you ever experienced sexual abuse? ☐ **Yes** ☐ **No**

Have you ever experienced physical abuse? ☐ **Yes** ☐ **No**

Do you have any current legal problems? ☐ **Yes** ☐ **No**

I hereby certify that all information provided in this document is true to the best of my knowledge.

Signature: _____ Date: _____

Referral Information: How did you learn about the Gronowski Center?

☐ Palo Alto Medical Foundation (PAMF)
☐ Santa Clara County Mental Health
☐ San Mateo County Mental Health
☐ Kaiser
☐ Stanford University or Hospitals
☐ El Camino Hospital
☐ Palo Alto Unified School District
☐ Sequoia Union High School District
☐ Other School or School District (please specify)
☐ Other Community Agency/Clinic (please specify)
☐ Mental Health Practitioner (Name if known)
☐ Medical Doctor (Name if known)

☐ Friend/Family Member
☐ Gronowski/PAU website

☐ Help Line/Referral Service
☐ Other: Please specify below:

Name of Person/Agency _____ Contact Person? _____

Address_____

_____

Telephone Number: ( )