Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected as confidential information.

Personal Information Name:_____
Date: _____
Parent/Legal Guardian (if under 18): _____
Address: _____
Home Phone: ___ _____ May we leave a message? ▫ Yes ▫ No
Cell/Work/Other Phone: _____ May we leave a message? ▫ Yes ▫ No
Email: _____ May we leave a message? ▫ Yes ▫ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.
DOB: _____ Age: _____ Gender: _____
Marital Status: ▫ Never Married ▫ Domestic Partnership ▫ Married ▫ Separated ▫ Divorced ▫ Widowed
Referred By (if any): _____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ▫ No ▫ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? ▫ Yes ▫ No If yes, please list:
_____
_____

Have you ever been prescribed psychiatric medication? ▫ Yes ▫ No If yes, please list and provide dates:
_____
_____

General and Mental Health Information

How would you rate your current physical health? (Please circle one)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
_____
_____

How would you rate your current sleeping habits? (Please circle one)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

How many times per week do you generally exercise?

_____

What types of exercise do you participate in?

_____

Please list any difficulties you experience with your appetite or eating problems:

_____

Are you currently experiencing overwhelming sadness, grief or depression? ▫ No ▫ Yes If yes, for approximately how long?_____

Are you currently experiencing anxiety, panics attacks or have any phobias? ▫ No ▫ Yes If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? ▫ No ▫ Yes If yes, please describe:

_____

Do you drink alcohol more than once a week? ▫ No ▫ Yes If yes, approximately how frequently?

_____

How often do you engage in recreational drug use? ▫ Daily ▫ Weekly ▫ Monthly ▫ Infrequently ▫ Never

Are you currently in a romantic relationship? ▫ No ▫ Yes If yes, for how long?

_____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

What significant life changes or stressful events have you experienced recently?

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Please Circle and List Family Member

Alcohol/Substance Abuse yes / no _____
Anxiety yes / no _____
Depression yes / no _____
Domestic Violence yes / no _____
Eating Disorders yes / no _____
Obesity yes / no _____
Obsessive Compulsive Behavior yes / no _____
Schizophrenia yes / no _____
Suicide Attempts yes / no _____

Additional Information 1. Are you currently employed? ▫ No ▫ Yes If yes, what is your current employment situation?

_____
_____

Do you enjoy your work? Is there anything stressful about your current work?

_____
_____

Do you consider yourself to be spiritual or religious? ▫ No ▫ Yes If yes, describe your faith or belief:

_____
_____

What do you consider to be some of your strengths?

_____
_____

What do you consider to be some of your weaknesses?

_____
_____

What would you like to accomplish out of your time in therapy?

_____
_____