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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: _____

Address: _____

Home Phone: _____ May I leave a message? □ Yes □ No

Cell or Work Phone: _____ May I leave a message? □ Yes □ No

Email: _____ May I send 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

How do you identify your sexual orientation? _____

Referred By (if any): _____
May I thank this individual for the referral? □ Yes □ No

History

Have you previously received any type of mental health services?

□ No □ Yes, previous therapist/doctor: _____

Have you ever been prescribed psychiatric medications? □ Yes □ No
If yes, please list and provide dates:

Are you currently taking **any** prescribed medications? □ Yes □ No
If yes, please list name, dosage, and prescriber:

General and Mental Health Information

1. 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:

_____

_____

_____

2. 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:

_____

3. How many times per week do you generally exercise?

_____

What types of exercise do you participate in?

_____

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

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe (body location, frequency, intensity):
_____
_____

8. Do you drink alcohol more than once a week? □ No □ Yes

If yes, how frequently and in what amounts? _____
_____

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. 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 currently?
_____

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

12. Do you use any specific methods for managing stress? □ No □ Yes

If yes, please describe: _____
_____

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	List Family Member/s
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?

_____
_____

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

3. What do you consider to be some of your strengths?

_____
_____
_____

4. What do you consider to be some of your weaknesses?

_____
_____
_____

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

_____
_____
_____