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: Yes No

Home Phone: May we leave a message? ◯ ◯

Cell/Work/Other Phone: May we leave a message? ◯ ◯

Email: May we leave a message? ◯ ◯

**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

1. How would you rate your current physical health? (Please check 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 check 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, panic attacks or have any phobias?

If yes, when did you begin experiencing this?

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

If yes, please describe:

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

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?

11. 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

	Yes	No	List Family Member
Alcohol/Substance Abuse	◯	◯	_____
Anxiety	◯	◯	_____
Depression	◯	◯	_____
Domestic Violence	◯	◯	_____
Eating Disorders	◯	◯	_____
Obesity	◯	◯	_____
Obsessive Compulsive Behavior	◯	◯	_____
Schizophrenia	◯	◯	_____
Suicide Attempts	◯	◯	_____

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?