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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:_____

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

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 sadness, grief, anxiety 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: _____

   _____

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.)

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 ideation? Attempt? yes / no _____

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?

   _____

   _____

   _____

6. Medical History: Check any of the following that may apply to you:

❑ NONE listed	❑ insomnia	❑ taking dangerous drugs	❑ can't make decisions
❑ anxiety	❑ recurrent dreams	❑ allergies	❑ over ambitiousness
❑ headache	❑ nightmares	❑ asthma	❑ financial problems
❑ dizziness	❑ hallucinations	❑ sexual identity issues	❑ gambling
❑ fainting spells	❑ flash backs	❑ tendency to isolate	❑ job problems
❑ lack of appetite	❑ inferiority feelings	❑ irritability	❑ can't keep a job
❑ over eating	❑ feeling tense	❑ shyness with people	❑ procrastination
❑ poor nutritional habits	❑ feeling panicky	❑ difficulty making friends	❑ career dissatisfaction
❑ stomach trouble	❑ fears & phobias	❑ victimization	❑ relationship problems
❑ bowel disturbances	❑ obsessions	❑ fear of people	❑ intimacy issues
❑ often tired	❑ depression	❑ fear of heights	❑ trust issues
❑ unable to relax	❑ suicidal ideas	❑ poor living conditions	❑ driven to perfection
❑ sex addiction	❑ taking tranquilizers	❑ unable to experience pleasure	❑ body shame
❑ trust issues	❑ alcoholism	❑ always worried about something	❑ negative self-talk
❑ divorce	❑ PTSD	❑ difficulty with vacations/weekend	❑ follow through on goals
	❑ aggression	❑ family problems	❑ setting goals
	❑ control issues	❑ passive aggressive	❑ transition issues