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: _____

Preferred Name: _____

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

DOB: _____ Age: _____ Gender: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Referred By (if any): _____

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?

Daily Weekly Monthly Infrequently Never

How often do you engage in recreational drug use other than alcohol?

Daily Weekly Monthly Infrequently Never

If yes, what drug(s)?

_____

_____

How would you describe your sexual orientation? _____

Marital Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Please list names and ages of any children:

_____

_____

_____

Psychiatric History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? No Yes

If yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? No Yes

If yes, please list:

_____

_____

Have you ever had a psychiatric hospitalization? □ Yes □ No

If yes, please list and provide dates:

_____

_____

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

Additional Information

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? _____

_____

_____

What is your highest level of education completed? _____

Have you ever been physically abused: Yes No

Have you ever been sexually abused: Yes No

Have you experienced anything you would describe as trauma? Yes No
If yes, please briefly explain:

_____

_____

_____

Do you consider yourself to be spiritual or religious? Yes No
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? _____

_____

_____

_____

What else would you like for me to know?

_____

_____

_____ _____

Sign **Date**

_____ _____

Reviewed by clinician **Date**