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 Info	ormation			
Name:	Date:	Date:		
Parent/Legal Guardian (if under 18):				
Address:	·			
Home Phone:	May we leave a messag			
Cell/Work/Other Phone:	_ May we leave a messag			
Email:	May we leave a message	ge? □ Yes □ No		
*Please note: Email correspondence is not considered t DOB:	Age: Gender:			
DOB: A Marital Status:	rge Gender			
□ Never Married □ Domestic Partnership	p □ Married			
□ Separated □ Divorced	□ Widowed			
Referred By (if any):				
Histor	у			
Have you previously received any type of mental health etc.)?	ı services (psychotherapy, ps	sychiatric services		
□ No □ Yes, previous therapist/practitioner:				
Are you currently taking any prescription medication? If yes, please list:	□ Yes □ No			
Have you ever been prescribed psychiatric medication? If yes, please list and provide dates:	□ Yes □ No			
General and Mental H	ealth Information			
1. How would you rate your current physical health? (P.	lease circle one)			
	,			
Poor Unsatisfactory Satisfa	actory Good	Very good		
Please list any specific health problems you are currentl	y experiencing:			
		_		

2. How would you	rate your current sleeping	g habits? (Please circle	one)	
Poor	Unsatisfactory	Satisfactory	Good	Very good
Please list any spec	ific sleep problems you a	are currently experienc	ing:	
3. How many times	s per week do you genera cise do you participate in	lly exercise?		
4. Please list any di	fficulties you experience	with your appetite or	eating problems: _	
·	y experiencing overwhelmately how long?			
	y experiencing anxiety, puberiencing this			
·	y experiencing any chronibe:	•		
8. Do you drink alc	ohol more than once a w	eek?	Yes	
	u engage in recreational Weekly Monthly	drug use? □ Infrequently □	Never	
10. Are you current	tly in a romantic relations	ship?	□Yes	
If yes, for how long	g?			
	(with 1 being poor and 10			your relationship
11. What significan	nt life changes or stressfu	l events have you expe	rienced 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	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 any 2. Do you consider yourself to be spin If yes, describe your faith or belief:	ritual or religious?	□ Yes				
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?						