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:

_____

_____

_____

Are you any medication for physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.) YES NO

If yes, please list: _____

Are you having any problems with the quality of your sleep? (Please circle one) Yes No

Do any of the following apply to you list any specific sleep problems you are currently experiencing:

If yes, circle those that apply:
___ Sleep too much ____ Sleep too little ____ Poor quality _____ Disturbing dreams _____ Other: _____

Have you experienced a weight change in the past two months? Yes No

How many times per week do you generally exercise? _____days_____ minutes /hours_____

What types of exercise do you participate in?
_____

Are there any changes or difficulties in your appetite or eating habits? Yes No

If yes, check those that apply:

____ Eating less___ Eating more___ Bingeing ___ Restricting ____ Other _____

Have you experiencing weight change in the past two months? Yes No

Do you consume alcohol regularly? Yes No

In a month, how many times do you have four or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use? ___ daily___ monthly ___rarely ____ never

Have you felt depressed recently? □ No □ Yes
If yes, for approximately how long? _____

Have you had any suicidal thoughts recently? □ No □ Yes

If yes, how often? ____ Frequently _____ Sometimes ____ Rarely

Have you ever had suicidal thoughts in the past? □ No □ Yes
If yes, how long ago?
_____

Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this?
_____

Where? _____ Around who? _____ How often? _____

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?
_____

What significant life changes (employment, relocation, relationship, illness, loss of a loved one, etc.)? Describe.
_____
_____
_____
_____

Quick check

Circle the issues below that apply to you:

Extreme depressed mood	Mood swings	Extreme anxiety	Panic Attacks
Phobias	Sleep disturbance	Hallucinations	Memory lapse
Alcohol/substance abuse	Body complaints	Eating disorder	Repetitive thoughts
Anxiety	Time Loss	Repetitive behaviors	Homicidal thoughts
Suicide attempts	Trouble planning	Difficulty with relationships	

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? _____

_____

_____

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

If yes, describe your faith or belief: _____

_____

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**
Depression	yes/no	_____
Panic attacks	yes/no	_____
Anxiety disorders	yes/no	_____
Bipolar disorders	yes/no	_____
Alcohol/Substance Abuse	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	_____
Trauma history	yes/no	_____

Other information:

What do you consider to be some of your strengths?

_____

_____

_____

_____

List areas you would like to improve?

What do you like most about yourself?

What are some ways you cope with life obstacles and stress?

What are your goals for therapy? What would you like to accomplish during your sessions?

Is there anything else you would like to share?