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 I leave a message? □ Yes □ No
Cell/Work/Other Phone: _____ May I leave a message? □ Yes □ No
Email: _____ May I send a message? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*
DOB: _____ Age: _____ Gender: _____
Martial Status:

□ Single □ Married □ Divorced
□ Domestic Partnership □ Separated □ Widowed

Who do you currently live with? (check all that apply)

□ Live alone □ Roommates □ Partner/Spouse
□ Parent(s) □ Sibling(s) □ Children

Highest level of education:

□ Less than High School □ High School/GED □ Some college
□ Two-year degree □ Four-year degree □ Graduate/Professional degree

Referred By (if any): _____

Treatment History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, inpatient psychiatric treatment, etc.)? □ No □ Yes
Previous therapist/practitioner/hospital: _____

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 overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long?_____

6. Have you ever tried to harm or kill yourself? □ No □ Yes
How many times has this occurred in your life? _____

7. Do you have a history of violent behavior? □ No □ Yes
If yes, please elaborate: _____
_____

8. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, for approximately how long? _____

9. Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe: _____

10. Do you drink alcohol? □ No □ Yes How often? _____

11. Do you use recreational drugs? □ No □ Yes How often? _____
If yes, what drugs?_____

12. 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 satisfaction? _____

13. What significant life changes or stressful events have you experienced recently? _____
_____

14. Do you have a history of trauma? □ No □ Yes
If yes, please describe: _____
_____

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	_____
Bipolar	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	_____
Personality Disorder	yes / no	_____

Additional Information

1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your job satisfaction? _____

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? _____
_____
_____