Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session. Each member of the relationship should fill out this form separately. Please note: information provided on this form is protected as confidential information.

Personal Information

Name:_____ Date:_____
Address: _____
Home Phone: _____ May I leave a message? □ Yes □ No
Cell Phone: _____ May I leave a message and text message? □ Yes □ No
Email: _____ May I email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.
Emergency Contact Name/Relationship: _____
Emergency Contact Phone Number(s):_____
Referred By (if any): _____

DOB: _____ Age: _____ Gender: _____

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

□ Live alone □ Roommates □ Partner/Spouse (Name)_____
□ Parent(s) □ Sibling(s) □ Children (Names/Ages)_____

Martial Status:

□ Single □ Partnered, not living together □ Married
□ Divorced □ Domestic partnership, living together □ In a civil union
□ Committed relationship □ Widowed □ Other_____

Relationship Style

□ Monogamous □ Non-Monogamous (Polyamours, Open Relationship, etc.)
□ Questioning/Exploring □ Prefer not to answer
□ Other relationship structure/orientation _____

Total years together: _____ Years Married: _____ Marriage date: _____

Do you identify as: (check all that apply)

□ Asexual □ Heterosexual □ Homosexual
□ Bisexual □ Pansexual □ Polysexual

Dates of any prior marriages and divorces: _____

Highest level of education:

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

Occupational/School Information:
Are you currently employed? □ No □ Yes
If yes, who is your current employer/position? _____
If yes, are you happy at your current position? _____
Are you currently a student? □ No □ Yes, school's name: _____

Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:_____

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: _____

Have you been previously diagnosed with any mental health conditions? □ No □ Yes
If yes, please list:_____

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. Please list any difficulties you experience with your appetite or eating problems: _____
_____

4. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

5. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never
Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never
Have you ever tried to harm or kill yourself? □ No □ Yes
How many times has this occurred in your life? _____
Please describe each incident _____
_____
How were you supported after the suicide attempt or self-harm? _____
_____

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

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

8. Do you drink alcohol to the point of intoxication? □ No □ Yes How often? _____

9. Do you use recreational drugs to the point of intoxication? □ No □ Yes How often? _____
If yes, what drugs?_____

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

11. 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	_____

Relationship

1. Please rate your level of relationship happiness by circling the number that corresponds with your current feelings about the relationship:

1 2 3 4 5 6 7 8 9 10

(extremely unhappy) (extremely happy)

2. Have either of you threatened to separate or divorce (if married) as a result of the current relationship concerns?

□ Yes □ No If yes, who? ____ Me ____ Partner ____ Both of Us

3. Do you perceive that either you or your partner has withdrawn from the relationship?

□ Yes □ No If yes, which of you has withdrawn? ____ Me ____ Partner ____ Both of Us

4. What do you hope to accomplish through counseling? _____

_____

_____

5. What are some effective coping strategies that you've learned? _____

_____

_____

6. Please indicate the factors that are contributing to your relationship difficulties:

□ Affection	□ Holding other back	□ Sexual Issues
□ Agreeing on chores	□ Housing	□ Showing appreciation
□ Closeness	□ Unfaithful / Infidelity	□ Solving problems together
□ Common goals	□ In-laws	□ Spouses/partner's cleanliness
□ Common interests	□ Suspiciousness / Jealousy	□ Trusting each other
□ Communication	□ Parenting	□ Use of time
□ Finances	□ Physical fighting	□ Verbal fighting
□ Friendships	□ Recreation	□ Drinking
□ Relatives	□ Having fun together	□ Drug use
□ Lack of love for one another	□ Bored	□ Religious beliefs
□ Lack of respect for one another	□ Excess pornography viewing	□ Changes in lifestyle/value
□ Physical abuse	□ Verbal abuse	□ Other:_____

7. Which of these problems, issues or questions do you wish to address in counseling at this time? Why now?

_____

_____

8. Which of these problems are you primarily responsible for and which are the responsibility of others? Who are these other persons? _____

_____

9. On a scale of 1 to 10 rate the current level of conflict between you and your partner.

1 2 3 4 5 6 7 8 9 10

Get along very well Constant Conflict

10. On a scale of 1 to 10 rate how well you and your partner communicate.

1 2 3 4 5 6 7 8 9 10

Communicate very well Always miscommunicating

9. Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does. _____

_____

_____

10. From whom do you receive support and encouragement? _____

_____

_____

11. What are your biggest strengths as a couple? _____

_____

_____