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
SSN:_____
Name of Employer:_____
Referred By (if any): _____

If you are using insurance:
Name of Insurance: _____
ID Number:_____ Group Number:_____

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: _____
_____

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. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____ 7.
Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe: _____
8. Do you drink alcohol more than once a week? □ No
9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently
10. Are you currently in a romantic relationship? □ No
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?
_____
11. What significant life changes or stressful events have you experienced 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 Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence Eating Disorders	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior 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 anything stressful about your current work? _____
_____
_____

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? _____
_____
_____