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:____________________

____

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 any chronic pain? □ No □ Yes

If yes, please describe: ____________________

6. What type of emotional distress are you experiencing on a daily basis? ____________

____

____

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

If yes, for approximately how long?____________________

8. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this?____________________

9. Are you experiencing any obsessive thinking (thoughts just can't get out of head)?
If so, what are they? ____________________

____

10. Are you engage in any compulsive behaviors? __________ If so, what kind? (repetitive, anxiety-neutralizing) ____________________

____

11. Are you feeling numb or inexplicably angry at this time? _____ If so, explain ____________

____

12. Are you feeling like you would want to harm yourself? _____ If so, how long? ____________

13. Was there a trigger or event that led you to feel this way?____________________

____

14. Are your thoughts, feelings, behaviors interfering with daily functioning? ______ If so, please explain: ____

____

15. Do you drink alcohol more than once a week? □ No □ Yes

16. How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

17. 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?

____

18. What significant life changes or stressful events have you experienced recently? __________

____

____

19. Are you becoming socially isolated or have you lost friends? _______ If so, for how long?

____

20. Are you losing interest in activities or hobbies? _________ If so, for how long? __________

____

Family Mental Health History

Is there any family history of mental health issues such as anxiety, schizophrenia, depression, suicide attempts, etc.? _____ If yes, please explain ___________________________________

____

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 role would you like faith discussion to play in therapy?

4. What do you consider to be some of your strengths?______________________________

____

____

____

5. What do you consider to be some of your weaknesses?____________________________

____

____

____

6. What would you like to accomplish out of your time in therapy?____________________

____

____

7. Please list anything else you want me to know. ________________________________

____

____