CLIENT INTAKE QUESTIONNAIRE

Please fill in the information below and bring it with you to your first session. Note: information provided on this form is protected as confidential information. See informed consent for details of limitations of confidentiality.

Personal Information

Name:____

Date: ______________________

Parent/Legal Guardian (if under 18): ____

Address:
____

Home Phone: ___ _______________________________
May we leave a confidential message? □ Yes □ No

Cell/Work/Other Phone: _________________________
May we leave a confidential message? □ Yes □ No

Email: ____
NOTE: Email correspondence is not considered to be a confidential medium of communication and will only be initiated by therapist for non-clinical information exchange. See informed consent for details.

DOB: ______________________________ Age: _______ Gender: ________________

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Referred By (if any):
____

Emergency Contact information to be used in the case of medical or psychiatric emergency and only information related to the emergency will be provided. Please refer to informed consent. Providing this information indicates that you understand and agree.

Name: ____

Best Phone Number: ____

History
Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes

If 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 medications:

____

____

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, grandma, etc.)

Alcohol/Substance Abuse	Yes No	
Anxiety	Yes No	
Depression	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	
Other	Yes No	

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?

____

Current Mental Health

1. Are you currently employed?
Please Circle
yes/no

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?

____

____

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