Client Intake Questionnaire

Personal Information

Note: All information contained in your file is confidential unless indicated through a release of information form.

Today's date:_______________

____

First Name Middle Initial Last Name

Date of Birth:________________ Age:___________ Gender:_____________

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.

Martial Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Referred By (if any): ____

Occupation:______________________ Employer:__________________________________

Highest Level of Education:____

Spouse/Partner Name:___________________ Age:_____ Occupation:___________________

Employer:_____________________________ Preferred Phone:__________________________

Name, ages and gender of children (if applicable):____

Name, ages and gender of siblings (if applicable):____

Name and phone number of guardian parents (**for minors only)**

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 issues you are currently experiencing:____

2. How would you rate you current mental health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific mental health concerns you are currently experiencing:____

3. 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:

____

____

4. How many times per week do you generally exercise? ______________________________________
What types of exercise do you participate in? ____

5. Please list any difficulties you experience with your appetite or eating problems: _______________
____

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

If yes, for approximately how long?____

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

If yes, when did you begin experiencing this? ____

8. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: ____

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

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

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

11. 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?
____

12. Do you enjoy your work? Is there anything stressful about your current work? ___________________
____
____

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

14. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: ____
____

15. What do you consider to be some of your strengths? ____
____
____
____

16. What do you consider to be some of your weaknesses? ______________________________________
____
____
____

17. What would you like to accomplish out of your time in therapy? _____________________________
____
____

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	________________________
Domestic Violence	yes / no	________________________
Eating Disorders	yes / no	________________________
Obesity	yes / no	________________________
Obsessive Compulsive Behavior	yes / no	________________________
Schizophrenia	yes / no	________________________
Suicide Attempts	yes / no	________________________
	Additional Information	