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 Infrormation

Client Name:_____ Date: _____

Address: _____

If Client is a Minor (under 18)

Parent/Legal Guardian: _____

School:_____Grade:_____

Fathers Name: _____

Fathers Address:_____

Fathers Home Phone:_____Cell Phone:_____

Mothers Name: _____

Mothers Address:_____

Mothers Home Phone:_____Cell Phone:_____

Home Phone: _____ May I leave a message? ☐ Yes ☐ No

Cell/Work/Other Phone: _____ May I leave a message? ☐ Yes ☐ No

Email: _____ May I 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?

☐ Very good ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor

Please list any specific health problems you are currently experiencing: _____
_____

2. How would you rate your current sleeping habits?

☐ Very good ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor

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 □ Yes

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

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.)

		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

1. Are you currently employed? ☐ Yes ☐ No

If yes, what is your current employment situation? _____
_____

Do you enjoy your work? Is there anything stressful about your current work? _____
_____
_____

2. What do you consider to be some of your strengths? _____
_____
_____
_____

3. What do you consider to be some of your weaknesses? _____
_____
_____
_____

4. What would you like to accomplish out of your time in therapy? _____
_____
_____