



# 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: **1** \_\_\_\_\_ **1**

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:

- |  |   |                                  |
|--|---|----------------------------------|
| <input type="checkbox"/> Never Married | <input type="checkbox"/> Domestic Partnership | <input type="checkbox"/> Married |
| <input type="checkbox"/> Separated     | <input type="checkbox"/> Divorced             | <input type="checkbox"/> 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:

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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: \_\_\_\_\_

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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

10. 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?

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11. What significant life changes or stressful events have you experienced recently? \_\_\_\_\_

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### 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

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? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date