

### Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.  
Information provided on this form is protected as confidential information.

#### PERSONAL INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian (if under 18) \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

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:  Male  Female  Other \_\_\_\_\_

Referred By (if any) \_\_\_\_\_

#### MARITAL STATUS

Never Married  Domestic Partnership  Married  Separated  Divorced  Widowed

#### HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

Yes  No 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 choose 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?  Yes  No

If yes, for approximately how long? \_\_\_\_\_

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

If yes, when did you begin experiencing this? \_\_\_\_\_

7. Are you currently experiencing any chronic pain?  Yes  No

If yes, please describe \_\_\_\_\_

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

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

Daily  Weekly  Monthly  Infrequently  Never

10. Are you currently in a romantic relationship?  Yes  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? \_\_\_\_\_

\_\_\_\_\_

## 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.)

**If yes, indicate family member(s)**

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

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? \_\_\_\_\_

Is there anything else you would like me to know?

**YOUR CONSENT TO PARTICIPATE IN PSYCHOTHERAPY**

\_\_\_\_\_  
Printed Client Name

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date