## 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:Parent/Legal Guardian (if under 18):			Date:		
Parent/Legal Guardian (if un	der 18):				
Home Phone: Cell/Work/Other Phone:			May we leave a message? □ Yes □ No		
			May we leave a message? □ Yes □ No		
Email:			May we leav	e a messag	ge? □ Yes □ No
	ondence is not o	considered to be	a confidentia	l medium (	of communication
DOB:		Age:		Gender:	
Martial Status:					
□ Never Married	□ Domestic	e Partnership	□ Marri		
□ Separated	□ Divorced		□ Wido	wed	
Referred By (if any):					
		History			
Have you previously receive etc.)?	d any type of m	nental health ser	vices (psychot	herapy, ps	ychiatric services
□ No □ Yes, previous thera	pist/practitione	er:			
Are you currently taking any If yes, please list:	prescription m	edication?	Yes	⊐ No	
Have you ever been prescribed psychiatric medication? If yes, please list and provide dates:			Yes	□ No	
	General and	d Mental Healt	h Informatio	1	
1. How would you rate your	current physica	al health? (Pleas	e circle one)		
Poor Uns	atisfactory	Satisfactor	y	Good	Very good
Please list any specific health	ı problems vou	are currently ex	periencing:		
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2. How would you	rate your current sleeping	g habits? (Please circle	e one)	
Poor	Unsatisfactory	Satisfactory	Good	Very good
Please list any spec	eific sleep problems you	are currently experience	cing:	
3. How many times	s per week do you genera cise do you participate in	lly exercise?		
4. Please list any di	ifficulties you experience	with your appetite or	eating problems: _	
5. Are you currently	y experiencing overwheli	ming sadness, grief or	depression? □ No	o □ Yes
If yes, for approxim	nately how long?			
6. Are you currently	y experiencing anxiety, p	anics attacks or have	any phobias? □ No	o □ Yes
If yes, when did yo	u begin experiencing this	s?		
7. Are you currently	y experiencing any chron	ic pain?	□ Yes	
If yes, please descr	ibe:			
8. Do you drink alc	cohol more than once a w	eek?   No	Yes	
-	ou engage in recreational Weekly   Monthly	•	□ Never	
10. Are you current	tly in a romantic relations	ship? □ No	□ Yes	
If yes, for how long	g?			
On a scale of 1-10	(with 1 being poor and 10	0 being exceptional), l	now would you rate	your relationship?
11. What significar	nt life changes or stressfu	l events have you exp	erienced 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.)

	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?							
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?							