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Client Intake Questionnaire

Please fill in the information below and bring it to our first meeting. Information provided on this form is protected as confidential information.

Personal Information

Name: ____ Date: __________________
Parent/Legal Guardian (if under 18 years old): ____
Address: ____
Home Phone: ____ May we leave a message? __Yes __ No
Mobile Phone *: ____ May we leave a message? __Yes __ No
Other Phone: ____ May we leave a message? __Yes __ No
Email *: ____ May we leave a message? __Yes __ No
Please note that email/text correspondence is not considered to be a confidential means of communication.
Date of birth: ______________ Age: __________ Gender __________
Health Insurance: ___________________________ID #__________________________ Group #_______________
Marital Status: ____

Referred by (How did you find me?): ____

Presenting Problem

Briefly describe why you are seeking therapy:
____
____
____
____

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

History

Have you previously received any type of mental health or substance use services (psychotherapy, psychiatric services, substance use, couples counseling, etc.)? __ Yes __No

Previous therapist/practitioner: ___________________________________ Location: _________________________
____

Are you taking any prescription medications for medical or psychiatric conditions? __ Yes __No:
Please list:
____

____
____

Have you experienced any of the following in the past few weeks?

Overwhelming sadness, depression or grief? __ Yes __ No. If yes, how long have you been experiencing this?
____

Anxiety, nervousness, panic or phobias? __ Yes __ No. If yes, how long have you been experiencing this?
____

How would you rate your current sleeping habits? (Please circle one)

Poor   Unsatisfactory   Satisfactory   Good   Very good

Please list any sleep problems you are currently experiencing:
____

Please describe any difficulties you are experiencing with your appetite or eating difficulties (e.g., decreased or increase appetite. Weight gain or loss).
____

Are you experiencing any chronic pain? __ Yes __ No. If yes, please describe?
____

If yes, how is your pain being treated or managed?
____

How frequently do you drink alcohol? _____________________________ How many drinks? ___________________

Do you use recreational drugs? __ Yes __ No Please list drugs used and frequency of use
____

Are you in a romantic relationship? __ Yes __ No If Yes, how long? _______________________________
One a scale of 1 – 10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? ______

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 (father, mother, grandmother/father, aunt/uncle, etc.) to you in the space provided.

	Please Circle	Family member relationship
Alcohol/Substance Abuse	Yes / No	______________________________
Anxiety/Panic/Phobia	Yes / No	______________________________
Depression	Yes / No	______________________________
Domestic Violence	Yes / No	______________________________
Eating Disorder	Yes / No	______________________________
Obsessive Compulsive Disorder	Yes / No	______________________________
Schizophrenia/Psychosis	Yes / No	______________________________
Bipolar/Manic-Depression	Yes / No	______________________________
Suicide Attempts	Yes / No	______________________________

Health

How would you rate your current physical health? (Please circle one)

Poor   Unsatisfactory   Satisfactory   Good   Very good

Please list any specific health/medical problems you are currently experiencing. Please include any chronic health issues, such as diabetes, asthma, high blood pressure, heart problems, etc.

____

____

How many times per week do you generally exercise? __________________

What types of exercise do you participate in? ____

How would you rate the healthful quality of your diet? (Please circle one)

Poor   Unsatisfactory   Satisfactory   Good   Very good

Additional Information

Are you currently employed? __ Yes __No

If yes, what is your current employment situation? ____

Do enjoy your work? What if anything is stressful about your current work situation?

____

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

If yes, please describe your faith or belief.

____

What do you consider to be some of your strengths?

____

____

____

What do you consider to be some of your weaknesses?

____

____

____

What would you like to accomplish during your time in therapy?

____

____

____