

# 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: \_\_\_\_\_

Address: \_\_\_\_\_

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?

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?

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.)

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? \_\_\_\_\_