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: ___________________________ Cell/Work/Other Phone: _____________________

May we leave a message? □ Yes □ No

Email: _______________________________________

Please note: Email correspondence is not considered to be a confidential medium of communication.

DOB: _____________________________ Age: _________ Gender: _________________

SS#:____________________ Race:________________ Ethnicity:________________

Martial Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Referred By: ____

In case of Emergency, Contact: Name: ____________________ Relationship: ________________
Phone: ___________________ Address: ____

Primary Care Physician: _________________________ Phone: ___________________________

Address: _________________________________ City, State and Zip:______________________
Permission to communicate with PCP about your treatment? □ Yes □ No

For children & adolescents:
Parents' marital status: ☐ never married ☐ married ☐ separated ☐ divorce ☐ widowed

	Mother (or Guardian)	**Father**
Name:	_____________________________	___________________________________
DOB:	_____________________________	___________________________________
Address:	___________________________	___________________________________
	___________________________________	___________________________________
Phone:	_____________________________	___________________________________
Employer:	___________________________	___________________________________
Address:	____________________________	___________________________________
	___________________________________	___________________________________

Custody Arrangement (for divorced/separated parents):
☐ informal (no court order) ☐joint legal custody ☐ sole legal custody (mother)
☐ sole legal custody (father) ☐ other: ___________________________________
Primary residence of child is with: ______________________________________

If custody agreement, informal or formal, includes shared custody, does the other custodial parent consent to treatment on behalf of their child(ren)? □ Yes □ No
If yes, please provide other custodial parent's signature here: ___________________________________
If no, please explain: ____

History
Have you previously received any type of mental health services (psychotherapy, psychiatric services, hospitalizations, etc.)?
□ Yes □ No
If yes, previous therapist/practitioner: ____

Are you currently taking any prescription medication? □ Yes □ No
If yes, please list including dosage amount/frequency:
____
____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list:
____
____

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:__________________________
____
When was your last physical/lab? Results? Findings? ____

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
If yes, please describe: ____

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never
Type of recreational drug:____

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? _____________
____
____

12. What, if any, significant life changes or life altering events did you experience when you were a child/young?____
____

13. Do you have any legal history? (Arrests, sentencing, DUIs, DWIs, incarceration, litigation, etc.) □ Yes □ No
If yes, please describe: ____
____

14. In your own words, what do you feel brings you here today? (Primary concern, presenting problem)
____
____

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(s) and if maternal/paternal
Alcohol/Substance Abuse Anxiety □ Yes □ No	______________________________________
Depression □ Yes □ No	______________________________________
Domestic Violence □ Yes □ No	____________________________________
Eating Disorders □ Yes □ No	____________________________________
Obesity □ Yes □ No	____________________________________
Obsessive Compulsive Behavior, 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 and/or religious? □ Yes □ No
If yes, describe your faith or belief: ____
____

3. What is your academic background? (Level of education/ degrees if relevant)___________________
____

4. Upon whom do you rely for social support? ____
____

5. What do you consider to be some of your strengths? ____
____
____
____

6. What do you consider to be some of your weaknesses? ____
____
____
____

7. What would you like to accomplish out of your time in therapy? ______________________________
____
____