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CLIENT INTAKE QUESTIONNAIRE

Please fill in the information below and bring it with you to your first session. This information will help me to understand these parts of your background, and allow us to increase our amount of time available for discussing your primary concerns. We will, of course, discuss some of these items in more detail as necessary.
Please note: information provided on this form is protected as confidential information.

Personal Information
Name:____ Date: ______________________
Parent/Legal Guardian (if under 18): ____
Address: ____
Home Phone: ____ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: ____ May we leave a message? □ Yes □ No
e-mail : _____________________________________ May we leave messages (appt. reminders only)? □ Yes □ No
DOB: _____________________________ Age: _______ Gender: ________________
Martial Status: □ Single □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed
Referred By (if any): ____

Treatment History and Current Status
1. Have you previously received any mental health services (psychotherapy, psychiatric services, testing, etc.)?
□ No □ Yes, previous therapist/practitioner(s):
____
____
Are you currently taking any prescription medication? □ Yes □ No If yes, please list your medication, dosages, and indicate who is prescribing (please attach additional sheet if necessary):
____
____
____
____
Have you ever been prescribed psychiatric medication? □ Yes □ No If yes, please list and provide dates:
____
____
2. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long?____
3. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? ____
4. Have you experienced being abused by someone? □ No □ Yes If Yes, please describe briefly if you are willing:
____
____
5. What significant life changes or stressful events have you experienced recently?
____
____

Name:____ Date: ______________________

General 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: ___________________________________

____

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 any chronic pain? □ No □ Yes

If yes, please describe:

____

____

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

If yes, please describe your typical alcohol usage:

____

7. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

If yes, please describe your typical substance and pattern of use:

____

____

8. Have you experienced any of the following (please circle):

	Please Circle	Please describe when and what happened
Brain Injury	yes / no	____
Concussion	yes / no	____
Loss of Consciousness	yes / no	____
Seizure	yes / no	____
Stroke or TIA	yes / no	____

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's relationship to you*
ADHD/Learning problems	yes / no	____
Alcohol/Substance Abuse	yes / no	____
Anxiety	yes / no	____
Autism	yes / no	____
Bipolar Disorder	yes / no	____
Depression	yes / no	____
Violence or Abuse	yes / no	____
Eating Disorders	yes / no	____
Schizophrenia	yes / no	____
Suicide Attempts	yes / no	____

Name:____ Date: ______________________

Additional Information

1. Are you currently in a committed relationship? □ No □ Yes

If yes, for how long? ____

If so, on a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

____

2. Do you have children? □ No □ Yes If Yes, please list their names and ages:

____

____

____

____

3. 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?

____

____

4. What is the highest level of education that you have completed:

____

What kind of grades did you typically earn? ____

5. Have you had a history of legal charges filed against you, or periods of incarceration? □ No □ Yes

If Yes, please describe:

____

____

____

6. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:

____

____

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

____

____

____

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

____

____

____

9. What would you like to accomplish out of your time in therapy?

____

____

____

____

____

____ ____________________

Client Signature (Client's Parent/Guardian if under 18) Date