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.

		Pe	ersonal Informa	ation		
Name:				D	ate:	
Parent/Legal Guar	dian (if ur	ider 18):				
Address:						
Home Phone:			May we	leave a messag	e? □ Yes □ No	
Cell/Work/Other P					ge? □ Yes □ No	
Email:						ge? □ Yes □ No
*Please note: Ema						
			Age:		Gender:	
Marital Status:	[amiad	- Domostic	a Dartmarahin	_ 1	Marmi ad	
□ Never w.		□ Domestic □ Divorced			Married Widowed	
□ Separate	u	□ Divorced	l	Ц,	Widowed	
Referred By (if any	y):					
			TT* /			
			History			
Have you previous etc.)?	ly receive	ed any type of m	nental health ser	vices (psy	chotherapy, ps	ychiatric services,
□ No □ Yes, pre	vious ther	apist/practition	er:			
Are you currently if yes, please list:	taking any	prescription m	edication?	Yes	□ No	
Have you ever bee If yes, please list a			medication?	Yes	□ No	
		~ .				
		General and	d Mental Healt	h Inform	ation	
1. How would you	rate your	current physica	al health? (Pleaso	e circle o	ne)	
Poor	Uns	atisfactory	Satisfactor	у	Good	Very good
Please list any spec	cific healt	h problems you	are currently ex	periencir	ıg:	

2. How would you	rate your current sleeping	g habits? (Please circle	one)	
Poor	Unsatisfactory	Satisfactory	Good	Very good
Please list any spec	cific sleep problems you a	are currently experienci	ng:	
3. How many time What types of exer	s per week do you genera cise do you participate in	lly exercise??		
4. Please list any d	ifficulties you experience	with your appetite or e	eating problems: _	
•	ly experiencing overwhelmately how long?		-	
•	ly experiencing anxiety, pour begin experiencing this			
·	ly experiencing any chror	•		
8. Do you drink ale	cohol more than once a w	eek? No	Yes	
_	ou engage in recreational Weekly	drug use? □ Infrequently □	Never	
10. Are you curren	tly in a romantic relations	ship?	Yes	
If yes, for how lon	g?			
	(with 1 being poor and 10			your relationship
11. What signification	nt life changes or stressfu	l events have you expe	rienced 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?								
Do you enjoy your work? Is there anything stressful about your current work?								
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?								