

Pathway To H.O.M.E Counseling and Wellness Services, LLC.

Client Intake Questionnaire

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:

Never Married Domestic Partnership Married

Separated Divorced 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:

Chief Compliant/Reason for Today's Visit:

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:

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? 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?

11. What significant life changes or stressful events have you experienced 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?

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?
