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: ________________________
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
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 Identity:_________________
Martial Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Do you identify as LGBTQQIA? □ Yes □ No
Do you have any tribal affiliation? □ Yes □ No
Do you identify as BIPOC (Black, Indigenous, Person of Color) □ Yes □ No

Referred By (specific professional/website/friend):
____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? How many years?

□ No □ Yes, previous therapists/practitioner: ____
(Optional) Can you share what types of issues you addressed in previous therapy?
____

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? (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.What types of exercise/moving your body do you participate in or enjoy? ____________________

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
On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate the quality of the relationship?
____

11. Do you have children? □ No □ Yes

12. How would you rate your relationship with your body/body image/appearance? On a scale of 1-10 (with 1 being poor and 10 being exceptional)

13. What significant life changes or stressful events, losses have you experienced recently? In the past couple of years?
____
____

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	________________________
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/challenges? ___________________________
____
____
____

5. What would you like to accomplish in therapy? What are some of your goals?__________________
____
____