# 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.

Member ID:_________________________________________Group:_________________________
Insurance Carrier:____________________________________________________________________
Insurance Phone: _______________________________

**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 send a message? □Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*
DOB: ______________________________ Age: _______ □ Male □ Female

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

Referral Source:
□ Insurance website □ People Can Talk website □ Other:
□ Psychologytoday.com □ Yelp

Emergency Contact:___________________________________Relationship:__________________
Address: ____________________________________________________________________
Home Phone:____________________________Cell/Work/Other Phone: _______________________

**Mental Health History**

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ Yes □ No 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:
______________________________________________________________________________
______________________________________________________________________________

Are you currently having thoughts of suicide? □ Yes □ No

Have you ever attempted suicide? □ Yes □ No

If yes, please provide number of times, method used, and dates:
______________________________________________________________________________
______________________________________________________________________________

## General Information

1. How would you rate your current physical health? (Please check 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 check 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

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

10. Are you currently in a romantic relationship? □ Yes □ No

If yes, for how long? _______________________________________________________________

11. On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_______________________________________________________________________________

12. 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? □ 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 or religious? □ Yes □ No

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 from your time in therapy? ______________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________