Client Intake Questionnaire

Please fill in the information below and return it prior to our first session.
Information provided on this form is protected as confidential information per HIPAA.

Personal Information

Name:_____Date: _____
Legal Name (if different) _____
Parent/Legal Guardian (if under 18): _____
Address:_____
Phone:_____May we leave a message? □ Yes □ No
Text/SMS: _____
Please note: Email and text correspondence are not considered to be secure communication.
DOB: _____ Age: _____ Pronouns _____
Marital Status:

□ Never Married □ Domestic Partnership □ Poly/Other
Separated/Divorced □ Married □ Widowed

History

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

□ No □ Yes, diagnosis if applicable: _____

Are you currently taking any prescription medication? □ Yes □ No
If yes, please list:

_____
_____
_____
_____

General and Mental Health Information

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

□ Poor □Unsatisfactory □Satisfactory □ Good □ Excellent
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 ☐ Excellent

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? □ No □ Yes

9. How often do you engage in recreational drug use, including alcohol and cannabis?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

What substances do you currently use:

_____

10. Are you currently in any romantic relationships? ☐ No ☐ Yes

If yes, for how long? _____

Overall, are you happy with this relationship/these relationships?

_____

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.)

	Check one	List Family Member
Alcohol/Substance Abuse	☐No ☐Yes	
Anxiety	☐No ☐Yes	
Depression	☐No ☐Yes	
Domestic Violence	☐No ☐Yes	
Eating Disorders	☐No ☐	
Personality Disorders	☐No ☐Yes	
Schizophrenia	☐No ☐	
Suicide Attempts	☐No ☐Yes	

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? _____

_____

_____