

Client Intake Questionnaire

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

PERSONAL INFORMATION

Name: _____ Date: _____

Parent/Legal Guardian (if under 18): _____

DOB: _____ Age: _____ Gender: _____

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact Name _____ Phone Number _____

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.*

Would you like courtesy appointment reminders? ☐ Yes ☐ No

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:

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	Yes / No	Family member
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	

Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

GENERAL MENTAL HEALTH INFORMATION

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. Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing)	Yes / No

Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

6. Are you currently experiencing overwhelming sadness or grief? ☐ No ☐ Yes

If yes, for approximately how long? _____

7. Are you currently experiencing anxiety, panics attacks or have any phobias? ☐ No ☐ Yes

If yes, when did you begin experiencing this? _____

8. Are you currently experiencing any chronic pain? ☐ No ☐ Yes

If yes, please describe: _____

9. Do you drink alcohol more than once a week? ☐ No ☐ Yes

10. How often do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

11. 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?

12. What significant life changes or stressful events have you experienced recently? _____

13. Please briefly describe your goals for therapy?
