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. If you need a more private place, besides your home to complete this questionnaire, you are welcome to come early to your appointment and fill this out in the waiting room of my office.

Personal Information

Name: _____ Date: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell 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. I will not send you emails unless you explicitly state this is the best or only way to communicate with you. You will also be required to sign a release of liability for any type of electronic communications.*

DOB: _____ Age: _____ Gender Identity: _____

Emergency Contact and relationship to you: _____

Contact information for emergency contact: _____

Reasons for Seeking Therapy:

What is your major complaint or the reason for seeking therapy? _____

_____

How long have this been bothering you? _____

Have you suffered from this complaint in the past (circle one)? Yes/ No

Have you seen a previous therapist or physician for this complaint? Please list names, type of treatment and length of treatment? _____

_____

What makes this complaint worse? _____

What makes this complaint better? _____

Check Current Symptoms:

☐ Anxiety

☐Appetite Issues

☐Avoidance

☐Crying Spells

☐Depression

☐Excessive Energy

☐Fatigue

☐Guilt

☐Hallucinations

☐Impulsivity

☐Irritability

☐Libido Changes

☐Loss of Interest

☐Panic Attacks

☐Racing Thoughts

☐Risky Activity

☐Sleep Changes

☐Suspiciousness

Please list any other symptoms not covered above:

_____

_____

_____

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

_____

_____

Are you currently experiencing and suicidal ideation (circle one)? Yes/ NO

Do you have a history of past suicide attempts (circle one)? Yes/ No

If so, how may times? And were you hospitalized? Please provide details here: _____

_____

Medical History:

Are you currently taking any prescription medication? □ Yes □ No

If yes, please list:_____

_____

Do you have any previous mental health diagnoses (circle one)? Yes / No

If so, who have you seen for treatment? Please list any therapist and physicians: _____

_____

Dates treated: _____

Have you ever been prescribed psychiatric medication? Yes/ No

If yes, please list and provide dates: _____

_____

Do you have any allergies to medications? If so, list here: _____

_____

Do you have any medical diagnoses? Please list them here: _____

_____

Who is your primary care physician? _____

When was the last time you saw your physician? _____

When is your next scheduled appointment with your physician? _____

Do you see any specialty physicians (e.g. Neurologist, Nephrologist, Oncologist etc.)? If so, please list their names: _____

_____

Do you engage in any alternative health practices (e.g. herbal medicine, meditation, yoga, acupuncture)? Please list: _____

_____

Do you have a Durable Power of Attorney for health care? If so, who is that person? _____

_____

If you do not have a DPAHC, would you like support in completing that paperwork (circle one)? Yes/ No

Family History

Were you adopted? If yes, at what age? _____

How is your relationship with your mother? _____

_____

How is your relationship with your father? _____

_____

Siblings and their ages: _____

Are your parents married (circle one)? Yes/ No

Did your parents divorce? If yes, how old were you? _____

Did your parents remarry? If yes, how old were you? _____

Who raised you? Where did you grow up? _____

In the section below, identify if you have 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 yes or no and List Family Member relationship:

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 _____

Bipolar Disorder: yes/ no _____

Schizophrenia: yes / no _____

Suicide Attempts: yes / no _____

Please list any other pertinent family history: _____

_____

Do any of your family members have serious medical conditions? If yes, please list condition and family member relationship: _____

_____

_____

Current Status

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? _____

_____

_____

Marital Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

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

If yes, for how long? _____

How would you rate your relationship with your partner (circle one)?

Poor Unsatisfactory Satisfactory Good Very good

Can you name anything specifically that you think would improve your relationship? _____

_____

_____

Who are the primary people in your life who provide the most support to you? _____

_____

What is your sexual orientation? _____

Are you sexually active (circle one)? Yes/ No

Do you have children? Yes/No

If yes, how many and how is your relationship with your children? _____

_____

Do you consider yourself to be a spiritual or religious person? □ No □ Yes

If yes, describe your faith or belief: _____

_____

_____

Please describe any specific cultural practices or influences (e.g. rituals, ceremonies, traditions, beliefs)?

_____

_____

_____

General 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 or diagnoses you are currently experiencing: _____

_____

_____

Are there any specific goals you have regarding your physical health? _____

_____

How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please describe any sleep problems you are currently experiencing: _____

_____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

What are your special interests or hobbies? _____

_____

Please list any difficulties you experience with your appetite or eating problems: _____

_____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe symptoms and what you do to cope: _____

_____

Do you drink alcohol? □ No □ Yes How often and how much do you drink? _____

Do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

If so, what types and how often? _____

Do you smoke cigarettes? Yes/ No. If so, how many cigarettes do you smoke per day? _____

Do you drink caffeinated beverages? If so, how many per day? _____

Have you ever abused prescription drugs? If yes, which ones? _____

Have you ever been arrested? If yes, when and why? _____

_____

Are you currently on probation (circle one)? Yes/ No

Additional Information

What do you consider to be some of your strengths? _____

_____

_____

_____

What would you like to accomplish out of your time in therapy? _____

_____

_____

_____

When you no longer need therapy services, what will that look like or feel like? _____

_____

_____

_____

Please write anything else here that you feel is important for me to know: _____

_____

_____

_____

_____

_____