Client Intake Questionnaire

Please note: information provided on this form is protected as confidential information.

Personal Information

Name:____ Date: ______________________

DOB: ________________________Age: _______ Birth Gender: M / F Identified Gender M / F

Do you identify as: Straight, Gay, Bisexual, Lesbian, Transgender, Other ______________________

Ethnicity_____________________

Parent/Legal Guardian (if under 18): ____

Address: ____Zip Code___________

Primary Phone: ________________________________ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _________________________ May we leave a message? □ Yes □ No

May we correspond through Text? □ Yes □ No

Email: _______________________________________ May we correspond through Email? □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential medium of communication. **

Referred By (if any): ____

Martial Status**:**

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

Insurance Information

Insurance Company: _____________________________

Insurance ID #: _________________________________

Education / Employment

Are you currently employed? □ Yes □ No

Where/ Type of work ____

Are you currently in school? □ Yes □ No.

Where/ Grade____

What was your highest level of education completed ?____

Family History

Who do you live with? Please list ages too:

____

____

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 then 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 ____

Mental Health History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner: ____

Have you even been hospitalized for psychiatric reasons? □ Yes □ No
When/ Where:
____
____

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. 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 any chronic pain? □ No □ Yes
If yes, please describe: ____

6. Do you drink alcohol more than once a week? □ No □ Yes
7. How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

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

If yes, for how long? ____
On a scale of 1-10 (1 being poor and 10 being exceptional), rate your relationship? _____________

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

Family divorce or separation
Death in the family
Change in school or job
Change of job for parent or caregiver
Family move
Family accident or illness
Death of a close relationship
Personal/family financial problems
Other_______________________

10. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long?____

11. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? ____

12. Have you experienced any:

Emotional Abuse □ No □ Yes

Physical Abuse □ No □ Yes

Sexual Abuse □ No □ Yes

13. Are you experiencing any of these symptoms? Please circle all that apply.

Depressed mood, angry, excessive crying
Loss of interest or pleasure
Low energy; fatigued
Change in weight or appetite
Changes in sleep pattern
Feelings of hopelessness, worthlessness or excessive guilt
Difficulty concentrating; easily distracted
Grief over death or loss of loved one
Racing thought
Extreme highs and lows in mood

Hears voices or noises inside head
Sees things that aren't really there
Delusional beliefs
Paranoid; suspicious
Reports having multiple personalities
Seems detached from reality

Panic attacks or intense anxiety
Difficulty breathing, dizziness, nausea
Excessive worry
Obsessive behavior or thoughts
Nightmares
Avoids others, shy, withdrawn
Fears of dying
Fears of going crazy
Tense, unable to relax
Easily startled; overreacts
Angry, irritable, or pessimistic about future

Short attention span
Easily distracted
Does not seem able to listen
Disorganized, messy
Talks a lot; does not play quietly
Makes careless mistakes
Does not finish activities started
Loses things; forgets to do things
Fidgets or squirms
Overly active; restless

Often loses temper, angry, or resentful
Deliberately annoys others
Spiteful or vindictive
Defiant, argues with adults or authority

Violates rules and norms or rights of others
Cruel to people or animals
Forced someone into sexual behavior
Physically assaultive
Robbed or mugged someone
Threatens or intimidates others
Illegal acts
Lies or manipulates
Violates curfew, runs away, truant in school
Sets fires
Consistently irresponsible
Destroys property of others

Fears becoming fat
Refuses to stay at a minimum weight
Feels eating is out of control at times
Self-induced vomiting
Unrealistic body image
Binge eating
Has missed several menstrual periods
Diets, exercises, or uses laxatives excessively

Sexual dysfunction, lack of interest, does not enjoy sex
Paraphilias, other sexual problems
Gender identity confusion

Overly dependent; passive
Self-injurious or rages out of control
Has extreme mood swings
Consistently disregards others' safety; lacks empathy
Seems histrionic, attention seeking, overly dramatic
Fear of rejection or abandonment
Feels numb or empty inside
No interest in people or relationships
Perfectionist or does not complete projects on time
Arrogant; narcissistic; feels entitled

Additional Information

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

If yes, describe your faith or belief: ____

____

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

What do you consider to be some of your weaknesses? ____
____
____

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