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.

Personal Information

Name:_____ Date: _____

Preferred Name (if different):_____

Preferred Pronouns:_____

Parent/Legal Guardian (if under 18):_____

Address:_____

Home Phone: _____ Cell/Work/Other Phone: _____
May we leave a message? ▫ Yes ▫ No

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

Referred By (if any):_____

Emergency Contact:_____
Name Phone Relationship
(Please note: This will only be used in a life threatening emergency or if I feel your safety is at risk.)

Please List names/ages of any Children:_____

_____

DOB: _____ Age: _____

Ethnicity:_____ Education Level:_____

Gender Identity:
□ Male
□ Female
□ Transgender Male/Man of Trans Experience/FTM
□ Transgender Female/Woman of Trans Experience/MTF
□ Gender Queer
□ Additional Category (please specify):_____
□ Decline to Answer

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

Sexual Orientation:
□ Straight
□ Gay
□ Lesbian
□ Bisexual
□ Other:_____

History

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

_____

_____

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 overwhelming sadness, grief or depression? ▫ No ▫ Yes

If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panic 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 more than once a week? ▫ No ▫ Yes

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

▫ Daily ▫ Weekly ▫ Monthly ▫ Infrequently ▫ Never

10. 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?_____

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.)

	Please Circle	List Family Members
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Bipolar Disorder	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	_____
Trauma	yes/no	_____
Physical/Sexual Abuse	yes/no	_____

Additional Information

1. Are you currently employed?_____

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?

_____

_____

_____