# 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

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## *Personal Information*

| | | |
|---|---|---|
| *Full Legal Name:* | | |
| *DOB:* | *Age:* | *Gender Identity:* |
| *Preferred Name:* | | *Preferred pronouns:* |
| *Parent/Legal Guardian (if under 18):* | | |
| *Address:* | | |
| *Cell phone:* | | *Ok to leave message? yes/no* |
| *Work/other phone:* | | *Ok to leave message? yes/no* |

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

Referred By (if any): _____

Primary Care Physician (if any): _____

## *Personal History and Health Information*

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

Are you currently taking any medication (prescription and/or over the counter)?
□ No □ Yes, please list:

_____

_____

Do you have any allergies (food, medication, etc)?
□ No □ Yes, please list:

_____

Do you use any substances (nicotine, alcohol, caffeine, recreational drugs, etc)?
□ No □ Yes, please list, including average frequency & amount:

_____

_____

_____

Please provide a brief summary of your health history, including any chronic or new medical conditions and learning disabilities:

_____

_____

_____

Are you currently or recently experiencing any of the following (check all that apply):

| | | | |
|---|---|---|---|
| Frequent headaches | ❑ | Frequent thirst | ❑ |
| Dizziness or fainting | ❑ | Cardiovascular disease | ❑ |
| Stomache/GI problems | ❑ | Sleep problems | ❑ |
| Fatigue | ❑ | Vision problems | ❑ |
| Diabetes/Hypoglycemia | ❑ | Thyroid disease | ❑ |
| Seizure disorder | ❑ | Cancer (include type): | ❑ |
| Other current health concerns: | | | |
| | | | |

In this section, please circle whether yourself or a family member has a history of any of the following conditions. If it is a family member, please indicate their relationship to you (e.g. mother, father, sibling, etc).

| | | |
|---|---|---|
| Alcohol/Substance Abuse: | self/family | |
| Anxiety: | self/family | |
| Attention Deficit Disorder: | self/family | |
| Depression: | self/family | |
| Domestic Violence: | self/family | |
| Eating Disorders: | self/family | |
| Obsessive Compulsive Disorder: | self/family | |
| Panic Attacks: | self/family | |
| Personality Disorder: | self/family | |
| Schizophrenia: | self/family | |
| Suicide Attempts/Self-harm behavior: | self/family | |
| Trauma: | self/family | |
| Other mental health disorders/concerns not listed (and for whom): | | |
| | | |
| | | |
| | | |

***Additional Information***

1. Are you currently employed or in school? □ No □ Yes
If yes, what is your current employment or school grade?

_____

How would you rate your employment/school experience? (circle one):

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific problems you are currently experiencing:

_____

2. Are you currently in a romantic relationship □ No □ Yes
If yes, how would you rate your satisfaction with this relationship? (circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please describe any specific problems you are currently experiencing:

_____

_____

3. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief. Please include other relevant cultural information:

_____

_____

4. What do you consider to be some of your strengths?

_____

_____

5. What do you consider to be some of your struggles/challenges?

_____

_____

6. What would you like to accomplish from your time in therapy?

_____

7. Any other important information you feel is helpful for your therapist to know?

_____

_____

_____