Client Intake Questionnaire

Please complete the information below and bring with you to your first session.
Please note: Information provided on this form is protected as confidential information.

Personal Information

Name: ____ Today's Date: ____/____/____

Parent/Legal Guardian (if under 18): ____

Street Address: ____

City, State, and Zip Code: ____

Patient Date of Birth: ____/____/____ Age: _______ Gender: Male Female

Martial Status (circle one): SINGLE MARRIED DOMESTIC PARTNER
DIVORCED WIDOWED SEPARATED

How did you hear about our office? ____

Cell Phone Number: ______________________________

- this number belongs to (circle one): Patient Other: ___________________________

May we leave a voice message (circle one)? YES NO

May we send a text message (circle one)? YES NO

Home Phone Number: _____________________________

May we leave a voice message (circle one)? YES NO

Work Phone Number: _____________________________

May we leave a voice message (circle one)? YES NO

E-mail: ____

(please note; e-mail correspondence is not considered to be a confidential medium of communication)

May we contact you via e-mail (circle one)? YES NO

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? NO YES

please list: ____

____

Have you ever been prescribed psychiatric medication? NO YES

please list and provide dates: ____

____

GENERAL AND MENTAL HEALTH INFORMATION

(1) How would you rate your current physical health? (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? (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? YES NO

If yes, for approximately how long? ____

(6) Are you currently experiencing anxiety, panic attacks, or have phobias: YES NO

Is yes, when did you begin experiencing this? ____

____

(7) Are you currently experiencing any chronic pain? YES NO

If yes, please describe: ____

____

(8) Do you drink alcohol more than once a week? YES NO

(9) How often do you engage in recreational drug use? (circle one)

Daily Weekly Monthly Infrequently Never

(10) Are you currently in romantic relationship?: YES NO

If yes, for how long? ____________________________

On a scale from 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 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 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	______________________________

Additional Information

(1) Are you currently employed? YES NO

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? YES NO

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? _________________________

____

____

____

INSURANCE INFORMATION

Insurance Company Name: ____

Member Identification Number: ____

Group Number: __________________________________

Insurance Company Claims Mailing Address: (if a copy has been made of your insurance card, there is no need to complete this part): ___________________________________

____

Is the insurance plan under your name? YES NO

If no, who is the main policy holder? ____

What is your relationship to the policy holder? Spouse Dependent Other: please explain: ____

Name of Policy Holder? ____

Address, if different than the patient: ____

____

Birthdate of Policy Holder? _____/_____/_____

Phone Number for Policy Holder? ____

Do you have a secondary insurance? YES NO

If yes, what is the name of your secondary insurance company? _____________________

** Please be sure the front desk has a copy of your insurance card **

____ ________________

Patient (Parent/Legal Guardian) Signature Date