# INTAKE QUESTIONNAIRE

*Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.*

Client Name:

| Last | First | Middle |
|---|---|---|

Name of Parent/Guardian (if client is under 18 years of age):

| Last | First | Middle |
|---|---|---|

| Client's Gender<br>☐Male ☐Female ☐Other | Date of Birth | Age |
|---|---|---|

Please List Children and Ages:

| Name (s) | Age (s) |
|---|---|
| | |
| | |
| | |
| | |

Contact Information:

| Home Phone: | May we leave a message? ☐Yes ☐No |
|---|---|
| Work Phone: | May we leave a message? ☐Yes ☐No |
| Preferred Email: | May we email you? ☐Yes ☐No *Please note email correspondence is not considered to be a confident medium of communication. |

Emergency Contact

| Name: | Phone: | Relationship: |
|---|---|---|
| Name: | Phone: | Relationship: |

Referred by (if any):

| |
|---|

Reason for Visit:

| |
|---|

# GENERAL MENTAL AND MEDICAL HEALTH INFORMATION

**Client Mental Health History:**

Are you under the care of a psychiatrist? ☐Yes ☐No

Name of Psychiatrist: ___________________________

Address: ________________________________ City: _________________ State: _____ Zip: ____

List Any Medication and dosage prescribed by Psychiatrist:

| Medication Name | Dosage |
|---|---|
| | |
| | |
| | |

Have you ever been hospitalized for emotional problems? ☐Yes ☐No

If yes, when? ____________________________ Where? ___________________________________

Have you ever had individual therapy? ☐Yes ☐No – Date(s): ____________________________

Name of Therapist: _______________________________

Address: ____________________________ City: ________________ State: ______ Zip:_______

Phone: _______________________________

Have you ever been treated for substance abuse? ☐Yes ☐No – Date(s): ____________________

Are you currently experiencing overwhelming sadness, grief, or depression?
☐Yes ☐No If yes, for approximately how long? ________________________________________

Are you currently experiencing anxiety, panic attacks, or have any phobias?
☐Yes ☐No If yes, when did you begin experiencing this? _______________________________

Are you currently experiencing chronic pain?
☐Yes ☐No If yes, please describe. ___________________________________________________

Do you drink alcohol more than once a week? ☐Yes ☐No

How often do you engage in recreational drug use? ☐Daily ☐Weekly ☐Monthly
☐Infrequently

If applicable, what is your recreational drug of choice?

Are you currently in a romantic relationship? ☐Yes ☐No - If yes, for how long? ___________
On a scale of 1-10, how would you rate your relationship? ________________

What significant life changes or stressful event 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 (i.e. father, aunt, grandmother)

| Mental Health Area | Relationship |
|---|---|
| Alcohol/Substance Abuse | |
| Anxiety | |
| Depression | |
| Domestic Violence | |
| Eating Disorder | |
| Obesity | |
| Obsessive Compulsive Behavior | |
| Schizophrenia | |
| Suicide attempts/ideation | |

**Client Medical History**

Please feel free to add any additional information that you feel is needed.

Current Physician and/or Primary Care Provider ______________________________________

Address: __________________________ City: _______________ State: ______ Zip:_______

Phone: _____________________________

Medications Prescribed and Dosage

| Medication Name | Dosage |
|---|---|
| | |
| | |
| | |
| | |

Please list any and all physical illnesses that are now being treated by your current medical doctor.

______________________________________________________________________

______________________________________________________________________

How would you rate your current physical health? ☐Excellent ☐Good ☐Satisfactory ☐Unsatisfactory ☐Poor

Please list any specific health problems you are currently experiences. ______________________

______________________________________________________________________

How would you rate your current sleeping habits? ☐Excellent ☐Good ☐Satisfactory ☐Unsatisfactory ☐Poor

Please list any specific sleep problems you are currently experiences. ______________________

______________________________________________________________________

How many times per week do you exercise? ______________________________________

What types of exercises/physical activity do you participate in?: __________________________

Please list any difficulties you experience with your appetite or eating habits? _______________

______________________________________________________________________

What would you want your therapist to know about your physical and/or emotional health?

______________________________________________________________________________

______________________________________________________________________________

**Additional Information**

Are you currently employed? ☐Yes ☐No If yes, name of employer ____________________

Do you enjoy your work? Is there anything stressful about your current job? _______________

______________________________________________________________________________

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

If yes, please 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 with your time in therapy?__________________________

_____________________________________________________________________________