

# 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

Marital 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

If 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