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: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: ___ _____ May we leave a message? □ Yes □ No

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

Email: _____ May we leave a message? □ Yes □ No

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

DOB: _____ Age: _____ Gender: _____
Martial Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children and their ages: _____

_____

Referred By (if any): _____

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? □ 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. Have you ever had or currently having suicidal thoughts or attempted suicide? □ No □ Yes

If yes, when? _____

7. Have you ever had or currently having homicidal thoughts or attempts? □ No □ Yes

If yes, when? _____

8. Have you ever been or currently being physically or sexually abused? □ No □ Yes

If yes, when? _____

9. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

10. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

11. Do you drink alcohol more than once a week? □ No □ Yes

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

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

13. Are you currently or have you ever abused or been dependent on alcohol or other substances?
□ No □ Yes
If yes, when? _____

What Substances?_____

14. 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?
_____

15. 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 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? □ No □ Yes

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? _____

_____

_____

_____

_____

_____

_____

Designate a Family Member

Would you like to designate a family member or other individual with whom I (David Cooper, LPC-I), may discuss your medical condition?

Yes_____ No _____
Initial Initial

Who _____ Relationship _____

You may revoke or modify this specific authorization at any time in writing.

Client Signature _____

Counselor's Signature _____