Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session, if you can.

Information provided on this form it is confidential.

Personal Information

Name:____ Date: ________________

Parent/Legal Guardian (if under 18): ____

Address: ____

Home Phone: ______________________________ May we leave a message? ◻ Yes ◻ No

Mob/Work/Other Phone: ______________________ May we leave a message? ◻ Yes ◻ No

Email: ____________________________________ May we send a message? ◻ Yes ◻ No

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

DOB: ___________________ Age: ______________ Gender: _____________

Marital Status:

❑Never Married ❑Partnership ❑Married ❑Separated ❑Divorced ❑Widowed ❑Dating

Referred By (if any): ____

Next of Keen Information

Name: ____

Relationship: ______________ Contact: __________________ / ______________________

General and Mental Health Information

1. How are your physical exercise habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

3. Do you drink alcohol more than once a week? ❑Yes ❑No / If yes how many times? ________

4. Do you engage in recreational drug use? ❑Yes ❑No / If yes how often?

❑Daily ❑Weekly ❑Monthly ❑Infrequently ❑Never

5. What significant life changes/stressful events have you experienced recently? ____________________

____

____

6. Have you previously received any type of mental health services/treatments (psychotherapy, psychiatric services, etc.)? ❑Yes ❑No

If yes give previous therapist/practitioner: ____

7. Are you currently taking any prescription medication? ❑Yes ❑No

If yes, please list: ____

8. Have you ever been prescribed psychiatric medication? ❑Yes ❑No

If yes, please list and provide dates: ____

____

Other General Information

1. How long have you been in the current relationship? ______________________________

2. How would you rate your current relationship? (with 1 being poor and 10 being exceptional) _____

3. Do you consider yourself to be spiritual or religious? ❑Yes ❑No

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

____

5. What do you consider to be some of your weaknesses? ____________________________

____

What would you like to accomplish out of your time in therapy?

1) ____

2) ____

3) ____