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Client Intake Questionnaire

This information is gathered in order to serve as a beginning and as a foundation for our work together. Knowing what issues and concerns you bring to counseling, your history with counseling, and what you hope to accomplish is our starting place and informs the work we do together. Please be assured that ALL your information is maintained in a private and confidential manner.

Name: ____Today's Date: __________

Date of Birth: _____________ Place of Birth: ___________________ Gender__________

Address: ____Zip: _______________

Home Phone: ___________________________ May I leave a message? Yes No

Cell Phone: __________________________May I Text ? (circle) Yes No

Email:____

Referred by:____

Primary Physician: ____

Emergency Contact: _____________________________Phone: ____________________

Marital Status: ____Never Married ____Domestic Partnership _____Married

______Separated ____ Divorced ______Widowed

Occupation: ____________________________Employer: _________________________

Please state what concerns and/or you have at this time and how long you have been concerned.

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History

1, How would you rate your current physical health? (please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific problems you're currently experiencing:

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2. How many times/week do you generally exercise? ____________________________________

Types of exercise? ____

3. Please list any significant losses (death, divorce, job loss, moves, etc.) you have experienced in your life & the approximate dates: ____

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4. Previous Mental Health Provider?

____No ____Yes If yes, please list previous provider: ____________________________

5. Are you taking any prescription medication? ____ Yes ______ No

If yes, please list and provide dates: ____

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6. Which of the following are you experiencing at this time? (Check all that apply)

____ Sleep Difficulties ___Financial Concerns ___Reduced Energy/Fatigue ___Legal Concerns
____Reduced Concentration/Memory Issues ___Health Concerns ___Anxiety, Nervousness
____Panic Attacks ____Social Concerns ____Withdrawal from Others/Isolation
____Relationship Concerns ___Difficulty Expressing My Feelings ______Academic Concerns
____Family Conflicts ____Career Concerns _____Depression/Sadness _____Anger/Frustration
____Overwhelmed/Helpless _______Guilt _______Nightmares ____Appetite Changes
Other:

____:__________________________

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7. Please list all individuals living in your home, their relation to you, and each individual's age:

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8. Family Mental Health History	Please Circle	Family Member
Alcohol/Substance Abuse	yes / no	______________________
Anxiety	yes / no	______________________
Depression	yes / no	______________________
Domestic Violence	yes / no	______________________
Eating Disorders	yes / no	______________________
Obesity	yes / no	______________________
Schizophrenia	yes / no	______________________
Suicide Attempts	yes / no	______________________
Other ______________________		______________________

9. Please list your strengths or areas of success:

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10. Please state what you hope to achieve, improve, or change through counseling:

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Thank you very much for taking the time to complete this form. (2018)