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

Client's Name: _____ Today's Date: ___/___/___
(First, Middle, Last) MM DD YY

Parent/Legal Guardian (if under 18): _____ DOB: ___/___/___
(First, Middle, Last) MM DD YY

Address: _____ _____ _____
Street City, State Zip

Phone: _____ Cell: _____ Email: _____
(000) 000-0000 (000) 000-0000

Options where we may leave a message: (Check all that apply.) ☐ Phone ☐ Cell ☐ Email

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

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

Ages of Children (if any) _____

Referred to L.A. Counseling by (if any): _____

MEDICAL HISTORY

Your Primary Care Physican: _____ Primary Care Physician's phone: _____
(Physician's Name / Practice Name) (000) 000-0000

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No ☐ Yes (Please list the previous practitioner/therapist.) _____

Are you currently taking any prescription medication? ☐ No ☐ Yes (Please list below.)

_____

Have you ever been prescribed psychiatric medication? ☐ No ☐ Yes (Please list below.)

_____

[continued on the following page]

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6797 North High Street, Suite 100
Worthington, OH 43085

CLIENT INTAKE QUESTIONNAIRE

GENERAL AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (Please check only one.)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health problems you are currently experiencing: _____

_____

How would you rate your current sleeping habits? (Please check only one.)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep problems you are currently experiencing: _____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating problems: _____

_____

Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes. (Please indicate approximately how long.)

_____

Are you currently experiencing anxiety, panics attacks or have any phobias? ☐ No ☐ Yes (Please indicate when these started.)

_____

Are you currently experiencing any chronic pain? ☐ No ☐ Yes. (Please describe.)

_____

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

How often do you engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

Are you currently in a romantic relationship? ☐ No ☐ Yes (How long?) _____ How would you rate it, from 1 to 10? _____
(1 = 'poor' 10 = 'exceptional')

What significant life changes or stressful events have you experienced recently? _____

_____

_____

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FAMILY MENTAL HEALTH HISTORY

In the following section, identify if there is a family history of any of the listed items. 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(s):
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

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? _____

_____

_____

Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes (Please briefly describe your faith.) _____

_____

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 out of your time in therapy? _____

_____

_____

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