Client Intake Questionnaire

Please fill in the information below and return before your first session.

Please note: Information provided on this form is protected as confidential information.

I have read and understand the Statement of Confidentiality - Please check ( )

Personal Information

Name:_____ Date: _____

(For Israeli Clients Only: תעודת זהות_____)

Parent/Legal Guardian (if under 18) _____

Address: _____

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

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

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

Do you have children? □ Yes □ No Do they live with you? □ Yes □ No

If you have children, please list names and ages:

_____
_____
_____

Emergency contact person: _____ Relation to client: _____

Phone Number: _____ email: _____

Referred By (if any): _____

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

If yes, when did you begin experiencing this? _____

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

If yes, please describe: _____

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

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

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. 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? _____

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

_____

_____

_____

Family Mental Health History

In the section below, identify (by circling the answer) 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.)

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? _____
_____
_____