



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: _____

Marital 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): _____

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? _____
