Client Intake Questionnaire

Please complete this form and bring it to your first appointment.

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

Today's Date _____

Name_____ Date of Birth _____

Phone number _____ May we leave a message? _____

Cell number _____ May we leave a message? _____

Email _____

Home address _____

Preferred means of contact: _____ Note: Email is not considered secure communication.

Gender _____ Marital Status _____ Are you a student _____

Employer _____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____

EMERGENCY CONTACT PH NUMBER _____

Policy Holder

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder Address _____

Referred By _____

History

Have you previously had mental health services? _____ Please specify any services you have had, include

any MH hospitalizations _____

_____

Are you currently under a doctor's care for a mental health related condition _____

Please list all medications you are taking _____

General and Mental Health Information:

Please describe the presenting problem: _____

_____

_____

_____

_____

_____

Do you exercise _____ How often _____

Please specify any sleep issues you are having _____

Please specify any eating issues you are having _____

Are you experiencing overwhelming grief, sadness or depression? _____

How long has this been happening _____

Do you have thoughts of self-harm? _____ How often _____

Do you have a plan for self-harm _____ Do you have a safety plan? _____

How often do you use recreational drugs? _____ Alcohol? _____

Are you in recovery? _____

Additional Information I want my therapist to know: _____

_____

_____

_____

_____

Completed by Client:

Date: _____

Client Signature: _____