Client Intake Questionnaire

Please complete this form and bring it with you to your first session.

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

Personal Information

Name:_____ Date: _____

Parent or Legal Guardian if under age 18:_____

Address: _____

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

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

Email: _____ May we leave a message? □ Yes □ No

Preferred means of contact: _____

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

DOB: _____ Age: _____ Gender: _____

Are you a student? _____ Are you working _____

Place of employment _____

POLICY HOLDER INFORMATION:

Name of policy holder/Guarantor _____

Policy Holder's Date of Birth _____

Policy Holders Address: _____

Referred By (if any): _____

General and Mental Health Information

1. Have you previously received any type of mental health services?

□ No □ Yes

2. Are you under a Doctor's care for your depression or anxiety? □ No □ Yes

3. Please list any specific sleep problems or other symptoms you are currently experiencing:

_____

_____

4. Do you exercise? How often? _____

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

_____

6. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

Additional Information I would like my therapist to know:

_____

_____

_____

_____

Completed by client:

Signature:_____
Date: _____