her therapy space

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

Today's Date: ______________________

Name:____
Nicknames or Aliases: ____

DOB: ______________________________ Age: _______ Gender: ________________

Home Address:
____

Home Phone: _________________________________ May we leave a message? □ Yes □ No
Cell Phone: _________________________ May we leave a message? □ Yes □ No
Email: _______________________________________ May we leave a message? □ Yes □ No

Calls or e-mail will be discreet, but please indicate any restrictions:
____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Sexual Orientation:
□ Heterosexual □ Lesbian □ Gay □ Bisexual □ Queer □ Questioning □ Other

Referred By (if any):
____

Emergency Information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: ___________________________________
Phone: ___________________________________
Relationship: ______________________________

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

____
____

4. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes If yes, for approximately how long?____

5. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes If yes, when did you begin experiencing this?

____

6. Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe:

____

7. Chemical use
How much of each do you consume each week, on average?
Beer ________________________________
Wine ________________________________
Hard Liquor ___________________________

Have you ever felt the need to cut down on your drinking? □ No □ Yes
Have you ever felt annoyed by criticism of your drinking? □ No □ Yes
Have you ever felt guilty about your drinking? □ No □ Yes

Have you ever experienced "black outs" (e.g., unconsicousness; forgetting the events of the night) as a result of drinking? □ No □ Yes
If yes, please explain:

____

____

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

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

____

____

____

Family Mental Health History

In the section below, identify 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.)

Please Circle and List Family Member

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? □ No □ Yes If yes, what is your current employment situation?
____
____

2. Do you enjoy your work? Is there anything stressful about your current work?
____
____

3. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:
____
____

4. What do you consider to be some of your strengths?
____
____
____

5. What do you consider to be some of your weaknesses?
____
____
____

6. What would you like to accomplish out of your time in therapy?
____
____
____