Client Intake Questionnaire

Please fill in the information below and either email before your first session or print off and bring it with you.

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

Personal Information

Name:_____
*Parent/Legal Guardian (if under 18):*_____
Address:_____
Mobile Phone: ____ _____
Email: _____@_____
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: _____

Age: _____ Gender Description: _____ Martial Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Referred By (if any):

_____

_____

Personal History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes. If yes, who was/were your previous therapist/psychologist/psychiatrist?

_____

_____

Are you currently taking any prescription medication? □ Yes □ No
If yes, please list drugs and prescriber:

_____

_____

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, panics 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

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently

9a. What drugs do you use?

10. Are you currently in a relationship? □ Yes □ No
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 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	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 Behaviour	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? □ No □ Yes

If yes, describe your faith or belief and any previous faiths or affiliations

_____

_____

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?

6. Are there any other comments, questions or thoughts you would like to share at this stage?