**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**

Name: .............................................................................................. Date: ..............................................

Parent/Legal Guardian (if under 18): ..........................................................................................................

Address: .....................................................................................................................................................

Home Phone: ................................................. May we leave a message? Yes [ ] No [ ] (Please indicate)

Cell/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 [ ]

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:

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**General and Mental Health Information**

1. How would you rate your current physical health? (Please indicate one)

Poor [ ] Unsatisfactory [ ] Satisfactory [ ] Good [ ] Very good [ ]

Please list any specific health problems you are currently experiencing:

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2. How would you rate your current sleeping habits? (Please indicate one)

Poor [ ] Unsatisfactory [ ] Satisfactory [ ] Good [ ] Very good [ ]

Please list any specific sleep problems you are currently experiencing:

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3. How many times per week do you generally exercise? ............................................................................

What types of exercise do you participate in?

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

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5. Are you currently experiencing overwhelming sadness, grief or depression? Yes [ ] No [ ]

If yes, for approximately how long? ............................................................................................................

6. Are you currently experiencing anxiety, panics attacks or have any phobias? Yes [ ] No [ ]

If yes, when did you begin experiencing this? .............................................................................................

7. Are you currently experiencing any chronic pain? Yes [ ] No [ ]

If yes, please describe:

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8. Do you drink alcohol more than once a week? Yes [ ] No [ ]

If yes, how many units? ..............................................................................................................................

9. How often do you engage in recreational drug use?

Daily [ ] Weekly [ ] Monthly [ ] Infrequently [ ] Never [ ]

10. Are you currently in a romantic 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?

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

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**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.)

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?

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2. Do you consider yourself to be spiritual or religious? Yes [ ] No { ]

If yes, describe your faith or belief:

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

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

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5. How would you describe your support network?

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6. What would you like to achieve from your time in therapy?

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