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): _____

Age: _____ Date of Birth: _____ Gender: _____

Address: _____

Home Phone: _____ May I leave a message?_____

Cell or other Phone: _____ May I leave a message? _____

Occupation: _____

Employer: _____

Marital Status: _____

Referred by: _____

Family Physician: _____ Phone Number: _____

OTHERS LIVING IN YOUR HOME

Name: _____Age: _____Relationship: _____

Name: _____Age: _____Relationship: _____

Name: _____Age: _____Relationship: _____

Name: _____Age: _____Relationship: _____

Emergency Contact: _____ Phone: _____

Personal History

Have you ever received any type of mental health services (psychotherapy, psychiatric services)? When? Who was the practitioner?

Have you ever been prescribed psychiatric medication? If yes, please list what it was:

Are you currently taking any prescription medication? If yes, please list what it is:

Do you have any religious belief and/or religious affiliation?

What would you consider to be some of your strengths and weaknesses?

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