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

Email: _______________________________________
*Please note: Email correspondence will be used for billing purposes only.

DOB: _____________________________ Age: _______ Gender: _______________

Preferred pronoun ____

Marital Status:

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

How did you learn about Sonja Harrison:____

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. How many times per week do you exercise? _______________________________________

List types of exercise you engage 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 they begin? ____

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 □ Yes

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

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

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

If yes, for how long? ____

On a scale of 1-10 (1 is poor and 10 is 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. mother, father; grandmother, 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 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? ______________________________________
____

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: ____
____

3. Please list some of your strengths? ____
____
____
____

4. Please list some of your weaknesses? ____
____
____
____

5. What would you like to accomplish in therapy? _______________________________________
____
____
____