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: _____

DOB: _____ Age: _____ Gender: _____

Preferred pronoun _____

Marital Status:

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

How did you learn about Sonja Harrison:_____

Emergency Contact (name, relationship, phone number):

_____

(Please note: in case of an emergency, only your location and general information will be given)

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? _____

_____

_____

_____