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Individual and Couples Therapy
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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 I leave a message? Y/N
Cell/Work Phone: _____ May I leave a message? Y/N
Email: _____ May I leave a message? Y/N
** Please note: Email correspondence is not considered to be a confidential medium of communication.*
DOB: _____ Age: _____
Marital Status: _____
Referred by (if any): _____

Counselling History

Have you previously received any type of mental health services (psychotherapy, psychiatrist, psychologist, etc…)? **Y/N** If yes, previous therapist/practitioner: _____

General and Mental Health Information

1. Are you currently experiencing overwhelming sadness, grief or depression? **Y/N**
If yes, for approximately how long? _____

Have you been or are you on any medication for this? **Y/N** (Please list)
_____

2. Are you currently experiencing anxiety, panic attacks or have any phobias? **Y/N**
If yes, when did you begin experiencing this? _____
Have you been or are you on any medication for this? (Please list) _____
_____

3. Are you currently experiencing any chronic pain? **Y/N** If yes, please describe: _____
_____

4. Do you drink alcohol more than twice a week? **Y/N**

5. How often do you engage in recreational drug use? (please circle one)

Daily Weekly Monthly Infrequently Never

6. 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	Y/N	_____
Anxiety	Y/N	_____
Depression	Y/N	_____
Domestic Violence	Y/N	_____
Eating Disorders	Y/N	_____
Obsessive Compulsive Disorder	Y/N	_____
Schizophrenia	Y/N	_____
Suicide Attempts	Y/N	_____

Other _____

Additional Information

1. Are you currently employed? **Y/N**
If yes, what is your current employment? _____

Do you enjoy your work? Is there anything stressful about your current work? _____
_____
_____

2. Do you consider yourself to be spiritual or religious? **Y/N**
If yes, describe your faith or belief: _____
_____

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