

Client Intake Questionnaire

This is a fillable PDF, download it, fill it out, and email it to doctorj@[motivationlab.online](mailto:doctorj@motivationlab.online).

The information provided on this form is confidential.

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: _____ May we leave a message? Yes No

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: _____

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 generally exercise? _____

What types of exercise do you participate 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, panic attacks or have any phobias? No Yes

If yes, when did you begin experiencing this? _____

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

If yes, please describe: _____

8. How often do you drink alcohol? _____

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. father, grandmother, uncle, etc.)

	Please Check		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	Yes	No	_____
Behavior 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. What do you consider to be some of your strengths?

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

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

Motivation Lab Credit Card Authorization Form

Name on Card: _____

Card Number: _____ Exp. _____

Zip Code: _____ Code on Back: _____

I authorize charging my credit/debit/health account card for professional services. If I cancel less than 24 hours before my appointment or no-show, I recognize my card will be billed for the full session charge of \$150.00. Initials: _____

Check which applies:

_____ I am purchasing a 4-session package for the discounted rate of \$500.00.
Sessions must be used within 6 months, we don't refund unused sessions.
No shows or cancellations within less than 24 hours count as one session.

_____ I am paying for individual sessions, one at a time.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within 10 days. Initials: _____

Sign by typing name: _____

Date: _____