Paige O'Shea, MFT
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www.amindbodyandsoulhealing.com

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: _____Cell/Work/Other Phone: _____

Email: _____
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

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:

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Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:

_____

_____

General and Mental Health Information

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: _____

_____

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:

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating problems:

_____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

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Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe:

_____

Do you drink alcohol more than once a week? □ No □ Yes

If yes, please describe:

_____

How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long?

_____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

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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.)

Alcohol/Substance Abuse _____

Anxiety _____

Depression _____

Domestic Violence _____

Eating Disorders _____

Obesity _____

Obsessive Compulsive Behavior_____

Schizophrenia _____

Suicide Attempts _____

Are you currently employed? □ No □ Yes
If yes, name your employer, title and for how long?

_____

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

Additional Information

List Family Members / Support System

_____

_____

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____

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What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

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