Client Intake Questionnaire

Please complete the requested information in the questionnaire that applies to you and bring it with you to your first session. If this is couples or group counseling, everyone involved must complete separate questionnaires. ***PLEASE NOTE:*** *The information you provided on this form is protected as confidential information and will not be disclosed to anyone else without your written consent.*

Personal Information

Name ______________________________ Date ______________

Parent/Legal Guardian (if under 18) ______________________________

Address ____

Home Phone (____) ______________________ May we leave a message ( ) Yes ( ) No

Work Phone (____) ______________________ May we leave a message ( ) Yes ( ) No

Cell Phone (____) ______________________ May we leave a message ( ) Yes ( ) No

Other Phone (____) ______________________ May we leave a message ( ) Yes ( ) No

Email ______________________________ May we leave a message ( ) Yes ( ) No

*** PLEASE NOTE:** *Email is not considered a confidential medium of communication.*

Date of Birth ______________________ Age ( ) Gender ( ) Male ( ) Female

Marital Status

( ) Never Married ( ) Domestic Partnership ( ) Married

( ) Separated ( ) Divorced ( ) Widowed

Personal Health History

Do you currently have a physician/practitioner? ( ) Yes ( ) No
If yes, name of physician/practitioner ____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, mental health counseling, couples/group therapy)? ( ) Yes ( ) No
If yes, name of therapist/practitioner ____

Are you currently taking any prescription medication? ( ) Yes ( ) No
If yes, please list medications ____
____
____

Have you ever been prescribed psychiatric medication? ( ) Yes ( ) No
If yes, please list medications ____
____
____

How would you rate your current physical health? *(Please choose one)*

( ) Poor ( ) Fair ( ) Good ( ) Excellent

How would you rate your current mental health? *(Please choose one)*

( ) Poor ( ) Fair ( ) Good ( ) Excellent

How would you rate your current sleeping habits ? *(Please choose one)*

( ) Poor ( ) Fair ( ) Good ( ) Excellent

Are you having any sleep problems? ( ) Yes ( ) No
If yes, what problems? ____

How many times a week do you generally exercise? ____________________________

What types of exercise do you participate in? ____________________________

____

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

____

Do you currently experience overwhelming sadness, grief or depression? ( ) Yes ( ) No

If yes, how long have you been feeling this way? ____________________________

Do you currently experience anxiety, panic attacks or have any phobias? ( ) Yes ( ) No

If yes, how long have you been experiencing this? ______________________

Are you currently experiencing any chronic pain? ( ) Yes ( ) No

If yes, please describe. ____

____

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

Do you engage in recreational drug use? ( ) Yes ( ) No

If yes, how often? ( ) Daily ( ) Weekly ( ) Monthly ( ) Infrequently

Are you currently in a romantic relationship? ( ) Yes ( ) No

If yes, please describe ( ) Dating ( ) Engaged ( ) Married ( ) Extramarital

On a scale of 1-10, (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, mother, grandmother, uncle, etc.).

History			**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 Disorder	( ) Yes	( ) No	______________________
Schizophrenia	( ) Yes	( ) No	______________________
Suicide Attempts	( ) Yes	( ) No	______________________

Additional Information

Are you currently employed? ( ) Yes ( ) No

If yes, who do you work for and what is your title? ______________________

____

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

____

____

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

If yes, describe your faith or belief. ______________________________

____

____

What do you consider to be some of your strengths? ______________________________

____

____

____

What do you consider to be some of your weaknesses? ______________________________

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____

Who are the significant people in your life? Please provide a name and specify a relationship *(spouse, partner, parent, sibling, friend, coworker, girlfriend/boyfriend, etc.).*

____

____

____

____

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

____

____

____

____

____

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Couples Counseling Addendum

Name ____

Name of Partner ____

Relationship Status *(check all that apply)*

( ) Dating ( ) Living Together/Cohabitating

( ) Married ( ) Living Apart *(no separation agreement)*

( ) Divorced ( ) Separated

Length of time in current relationship ____________________________________

Have either of you been in individual counseling before? ( ) Yes ( ) No

What is/are the reason(s) you've chosen to come for couples counseling? _______________

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What steps have you taken to try and address this difficulty? ___________________________

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As you think about the primary reason that brings you here, how would you rate its frequency and overall level of concern at this point in time?

Concern	**Frequency**
( ) No Concern	( ) No Occurrence
( ) Little Concern	( ) Occurs Rarely
( ) Moderate Concern	( ) Occurs Sometimes
( ) Serious Concern	( ) Occurs Frequently
( ) Very Serious Concern	( ) Occurs Constantly

If so, give a brief summary of what you addressed. ____

____

____

____

What are your biggest strengths as a couple? ____

____

____

____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10

Are you still committed to making this relationship work? ( ) Yes ( ) No ( ) Not Sure

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does.

____

____

____

Have you had prior couples counseling about any of these problems? ( ) Yes ( ) No

If yes, when? ____________________________ Where? _______________________________________

By whom? ______________________________________ Length of treatment ______________________

Problems treated ____

____

What was the outcome?

( ) Very Successful ( ) Somewhat Successful ( ) Stayed the Same

( ) Somewhat Worse ( ) Much Worse ( ) Not Sure

Do either you or your partner drink alcohol to the point of intoxication or take drugs to the point of intoxication? ( ) Yes ( ) No

If yes, for either, who, how often, and what drugs or alcohol? _______________________________

____

____

Have either you or your partner struck, physically restrained, used violence against or injured the other person? ( ) Yes ( ) No

If yes, for either, who, how often, and what happened? ______________________________________

____

____

Have either of you threatened to separate or divorce *(if married)* as a result of the current relationship problem? ( ) Yes ( ) No Who? ( ) Me ( ) Partner ( ) Both

Which event? ( ) Separation ( ) Divorce

Do you perceive that either you or your partner is withdrawing or has withdrawn from the relationship? ( ) Yes ( ) No Who? ( ) Me ( ) Partner ( ) Both

How frequently have you had sexual relations during the last month? _________ *(# of times)*.

How enjoyable is your sexual relationship, (1) being extremely unpleasant and (10) being extremely pleasant?

1 2 3 4 5 6 7 8 9 10

How satisfied are you with the frequency of your sexual relations, (1) being extremely unsatisfied and (10) being extremely satisfied?

1 2 3 4 5 6 7 8 9 10

What is your current level of stress, (1) being no stress and (10) being high stress?

1 2 3 4 5 6 7 8 9 10

What is your current level of stress in the relationship, (1) being no stress and (10) being high stress?

1 2 3 4 5 6 7 8 9 10

Rank order the top three concerns that you have in your relationship with your partner, (1) being the most problematic and (3) being the least problematic.

1. ____________________
2. ____________________
3. ____________________

Thank you for completing this Client Intake Questionnaire. Please bring this with you during your first appointment. Please not that you will be asked to talk about your answers during therapy sessions, but your partner will not be shown this form.

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