

Client Intake Questionnaire

Please fill in the information below and bring it in before your first session.

Please note: information provided on this form is protected as confidential information. Only your therapist will see this document.

Personal Information

| Name: | Date: |
|---------------------------------------------------------------|------------------------------------------------|
| Parent/Legal Guardian (if under 18): | |
| Address: | |
| Home Phone: | May we leave a message? ☐ Yes ☐ No |
| Cell/Work/Other Phone: | |
| Email: | |
| *please note: email correspondence is not considered t | |
| DOB: Age: | Gender: |
| Marital Status: | |
| ☐ Never Married ☐ Domestic Partnership | ☐ Married |
| ☐ Separated ☐ Divorced | ☐ Widowed |
| Referred by (if any): | |
| History | L |
| Have you previously received any time of mental health etc.)? | services (psychotherapy, psychiatric services, |
| ☐ No ☐ Yes, previous therapist/practition | oner: |
| 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

| How would you | a rate your current p | mysicai neaith? (Please | circle one) | |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Poor | Unsatisfactory | Satisfactory | Good | Very Good |
| Please list any | specific health probl | ems you are currently e | experiencing: | |
| How would you | u rate your current s | leeping habits? (Please | circle one) | |
| Poor | Unsatisfactory | Satisfactory | Good | Very Good |
| Please list any s | specific sleep proble | ms you are currently ex | kperiencing: | |
| How many time | es per week do you | generally exercise? | | |
| What types of | exercise do you part | icipate in? | | |
| Please list any o | difficulties you expe | rience with your appeti | te or eating prob | lems: |
| Are you curren | tly experiencing ove | rwhelming sadness, gri | ef, or depression | ? □No □ Yes |
| If yes, for appro | oximately how long? | | | |
| Are you curren | tly experiencing anx | iety, panic attacks, or h | ave any phobias? | No □Yes |
| If yes, when did | d you begin experier | ncing this? | | |
| | | | | |
| If yes, please do | escribe: | | | |
| • | | | e⊈□ | |
| ☐ Daily | ☐ Weekly | ☐ Monthly ☐ I | nfrequently 🔲 | Never |
| . Are you curren | tly in a romantic rela | ationship? \square No | □Yes | |
| On a scale of 1- | -10, with 1 being po | or and 10 being excepti | | you rate your |
| . What significar | nt life changes or str | essful events have you | experienced rece | ntly? |
| | | | | |
| | Poor Please list any selection would you poor Please list any selection would you poor Please list any selection would would you poor Please list any selection when the you current of yes, for appropriate you current of yes, when did are you current of yes, please do not you drink all how often do you point all how often do you point would how often do you current of yes, for how on a scale of 1 yes, for how on a yes | Poor Unsatisfactory Please list any specific health probleman would you rate your current selections. Poor Unsatisfactory Please list any specific sleep probleman would with types of exercise do you part please list any difficulties you expense. Are you currently experiencing over lifyes, for approximately how long? Are you currently experiencing anx lifyes, when did you begin experiencing any lifyes, please describe: Do you drink alcohol more than one How often do you engage in recreating and paily weekly weekly are you currently in a romantic relationship? On a scale of 1-10, with 1 being poor relationship? What significant life changes or street. | Poor Unsatisfactory Satisfactory Please list any specific health problems you are currently of the second problems and specific health problems you are currently of the would you rate your current sleeping habits? (Please Poor Unsatisfactory Satisfactory Please list any specific sleep problems you are currently extended by the work of exercise do you generally exercise? What types of exercise do you participate in? Please list any difficulties you experience with your appetit Are you currently experiencing overwhelming sadness, gridly export of the year of the your currently experiencing anxiety, panic attacks, or have you currently experiencing any chronic pain? Are you currently experiencing any chronic pain? No You do you drink alcohol more than once a week? Do you drink alcohol more than once a week? Do you drink alcohol more than once a week? Do you drink alcohol more than once a week? Do you drink alcohol more than once a week? Do you drink alcohol more than once a week? No You weekly Monthly Are you currently in a romantic relationship? No If yes, for how long? On a scale of 1-10, with 1 being poor and 10 being exception relationship? What significant life changes or stressful events have you weekly are stressful events have | 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 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 prob Are you currently experiencing overwhelming sadness, grief, or depression if yes, for approximately how long? Are you currently experiencing anxiety, panic attacks, or have any phobias? 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 Yed How often do you engage in recreational drug use? Daily Weekly Monthly Infrequently Are you currently in a romantic relationship? No Yes |

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 | | |
|---------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------|--|--|
| Anxiety Depressior Domestic \ Eating Disc Obesity | violence orders Compulsive Behavior enia | yes / no | | | |
| | | Additional Information | | | |
| 1. | Are you currently employed? If yes, what is your current em | rrently employed? | | | |
| | Do you enjoy your work? | Is there anything stressful abo | out your current work? | | |
| 2. | | you consider yourself to be spiritual or religious? No Yes yes, describe your faith or belief: | | | |
| 3. | What do you consider to be some of your strengths? | | | | |
| 4. | What do you consider to be so | ome of your weaknesses? | | | |
| 5. | What would you like to accom | nplish out of your time in ther | apy? | | |
| | | | | | |

| | I authorize Adri Ramos, LCSW to exchange information with my primary care provider(please circle): Eric Ravitz, DO/ Caitlin Blau, DO/ Kelly Polus, PA-C/ Nicole Muskett, PA-C/ Other (please provide contact information below) | |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|
| Name of pro | ovider | |
| Address | 7in and a | |
| City, State, 2 | Zip code | |
| Phone num | ber, fax number (include area code) | |
| Signature o | of Patient (or representative) | |
| Date | | |
| If represen | tative, relationship to patient (i.e. parent, guardian, etc.) | - |