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:_____ May we leave a message? ☐ Yes ☐ No

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 time 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. Do you drink alcohol more than once a week? ☐ No Yes ☐
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, with 1 being poor and 10 being 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 Circle	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 Behavior	yes / no	_____
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? _____
   _____
   _____

☐ 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 provider*_____
Address _____
City, State, Zip code _____
Phone number, fax number (include area code) _____

Signature of Patient (or representative)_____

Date_____

If representative, relationship to patient (i.e. parent, guardian, etc.) _____