Counselling & Psychotherapy

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: _____Manchester_____

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

*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.)? 2018- Anxiety.

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No

If yes, please list: once a week – propanol- anxiety.

_____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No

If yes, please list and provide dates:

_____

_____

Current Symptoms (circle as appropriate to your emotions)

Anxiety/ Appetite Issues/ Avoidance/Crying Spells / Depression/ Excessive Energy/ Fatigue/Guilt/ Hallucinations /Impulsivity/ Irritability/Libido Changes/ Loss of Interest /Panic Attacks /Racing Thoughts /Risky Activity/ Sleep Changes /Suspiciousness

Aggravating Factors: _____

Relieving Factors: _____

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, panics 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

Were you adopted? If yes, at what age?

How is your relationship with your mother?

How is your relationship with your father?

Siblings and their ages:

Are your parents married?

Did your parents' divorce? If yes, how old were you? Did your parents remarry? If yes, how old were you?

Who raised you? Where did you grow up?

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 Behaviour 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. How do you perceive or endorse a "good"/ "bad" relationship _____

_____

4. Have you ever had problems is speaking up for yourselves_____

_____

5. What do you consider to be some of your strengths? _____

_____

_____

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

_____

_____

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

_____

_____

Any other information you would prefer to share to support therapy sessions:

_____

_____

_____

Therapist Notes (official Use)