CLIENT INTAKE QUESTIONAIRE

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: ______________________________ May we leave a message? o YES o NO
Cell/Work/Other: ____________________________ May we leave a message? o YES o NO
Email: _____________________________________ May we send a message? o YES o NO
**Please note: Email correspondence is not considered to be a confidential medium of communication.*
Date of Birth: __________________________ Age: ____________ Gender: _______________
Marital Status:
o Never Married o Domestic Partnership o Married
o Separated o Divorced o Widowed

Referred by: ____

What are the reasons you are seeking therapy at this time? ____
____
____
____

What significant life changes or stressful events have you experienced in the last 1 – 2 years (death, divorce, move, job change, etc.)?
____
____
_____

How would you like to see your life change as a result of your therapy at Inner Light Counseling? ___________________
____
____
____

Are you currently employed? o YES o NO
If yes, what is your current employment situation? ____
Do you enjoy your work? Is there anything stressful about your current work? ________________________________
____
_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
o NO o YES, previous therapist/practitioner: ____

Are you currently taking any medical and/or psychiatric prescription medication: o YES o NO
If yes, please list name, dosage, & frequency: ____
____
____
____

Name of Primary Care Physician/Pediatrician?
____
Phone Number _______________________________ Address
____

Name, address, phone number of child's school counselor? (if applicable)
____
____
_____

Name of person to be contacted in case of emergency?
____
Phone number: ____
(OVER)

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 (trouble falling asleep, waking up, etc.):
____
____
____

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

4. Are you currently experiencing overwhelming sadness, anger, grief, or depression? o YES o NO

If yes, for approximately how long?
____

5. Are you currently experiencing anxiety, panic attacks, or have any phobias? o YES o NO

If yes, when did you begin experiencing this?
____

6. Are you currently experiencing any chronic pain? o YES o NO

If yes, please describe:
____

7. Do you drink alcohol more than once a week? o YES o NO

8. How often do you engage in recreational drug use?
   o Daily o Weekly o Monthly o Infrequently o Never

9. History of allergic disorders?
   ____
   ____
   ____

Family Mental Health History

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 / Suicide Attempts yes / no ____

Other yes / no ____

Client Signature: ____ Date: ____________________

(or parent/guardian if applicable)