New Client Intake Questionnaire

Please note: information provided on this form is protected as confidential information.

Personal Information

Name: Date:

DOB: Gender:

Marital Status:

Address:

Telephone:

Is it ok to leave a message on this number? Yes ◯ No ◯

Referred By (if any):

History

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:

General and Mental Health Information

Please list any specific health problems you are currently experiencing:

Please list any specific sleep problems you are currently experiencing:

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

Are you currently experiencing overwhelming sadness, grief or depression? ◯ Yes ◯ No

If yes, for approximately how long?

Are you currently experiencing anxiety, panic attacks or have any phobias? ◯ Yes ◯ No

If yes, when did you begin experiencing this?

Are you currently experiencing any chronic pain? ◯ Yes ◯ No

If yes, please describe:

Do you believe you may have a problem with the amount/frequency you use alcohol or recreational substances? ◯ Yes ◯ No

If yes, please describe:

Please check the issues, which are affecting you:

- ☐ Afraid or anxious
- ☐ Feeling hopeless
- ☐ Has rituals
- ☐ Suicidal Thoughts
- ☐ Depressed
- ☐ Nightmares
- ☐ Unhappiness
- ☐ Doesn't talk
- ☐ Recurrent thoughts or actions
- ☐ Hurts self/Cutting
- ☐ Fights with others
- ☐ Sleep problems
- ☐ Lack of appetite
- ☐ Anger or irritability
- ☐ Worries all the time
- ☐ Shyness
- ☐ Isolation
- ☐ Defiant to authority
- ☐ Alcohol or drug use
- ☐ Lacks self-control
- ☐ Stress
- ☐ Mood Swings
- ☐ Argues with others
- ☐ Hyperactive
- ☐ Overeating
- ☐ Lacks motivation
- ☐ Stealing
- ☐ Learning problems
- ☐ Poor self-esteem
- ☐ Can’t concentrate
- ☐ Stubborn
- ☐ Wants attention from others all the time
- ☐ Nail Biting
- ☐ Loss of appetite
- ☐ Feeling Sad
- ☐ Pulls out hair
- ☐ Lying
- ☐ Destroys things
- ☐ Physical abuse
- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Can't pay attention
- ☐ Seems to hear or see things others can't
- ☐ Feels empty

For any above checked items, please provide additional details and/or describe reasons you are seeking services with me at this time: