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Psychotherapy for Children, Teens, Adults and Families
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CLIENT INTAKE QUESTIONNAIRE

Date_____

PERSONAL INFORMATION

NAME_____

AGE_____**DATE OF BIRTH**_____**GENDER**_____

ADDRESS_____

CITY_____ **STATE** _____

ZIP_____

PHONE: HOME _____ 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

Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Referred By (if any):

_____

EMPLOYMENT STATUS: __EMPLOYED __FULL-TIME STUDENT __PART-TIME STUDENT

NAME OF EMPLOYER _____

EMERGENCY CONTACT NAME_____

& PHONE NUMBER:_____

INSURANCE INFORMATION

INSURED'S NAME (If different from above)_____

CLIENT'S RELATIONSHIP TO INSURED: __SELF __SPOUSE __CHILD __OTHER

POLICY HOLDER'S ADDRESS (If different from above)

_____

DATE OF BIRTH_____**SOCIAL SECURITY#**_____

CITY_____ **STATE**_____**ZIP**_____

PHONE: HOME _____**WORK** _____

NAME OF INSURANCE COMPANY_____

INSURANCE ID#_____

GROUP/POLICY #_____

INSURANCE ADDRESS

_____

(From back of Insurance Card)

CITY_____**STATE**_____**ZIP**_____

PHONE_____

EMPLOYER_____

SECONDARY INSURANCE (IF APPLICABLE):

INSURED'S NAME

_____

ADDRESS_____

CITY_____ **STATE**_____**ZIP**_____

PHONE: HOME _____

WORK_____

DATE OF BIRTH_____**SOCIAL SECURITY #**_____

SECONDARY INSURANCE, if any

COMPANY_____

INSURANCE ID#_____

GROUP/POLICY

#_____

ADDRESS_____
(From back of Insurance Card)

CITY_____**STATE**_____**ZIP**_____

PHONE_____

EMPLOYER_____

OFFICE USE

Dx:_____

CPT:_____

Fee: _____ FIRST DATE OF

SERVICE:_____

GENERAL HEALTH/MENTAL HEALTH INFORMATION

Have you previously received any type 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 □
If yes, please list and provide dates:
_____
_____

Name of your psychiatrist or psycho pharmacologist
_____

Phone _____

Name of your Physician _____
Phone Number _____

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:
_____
_____

History of previous hospitalizations:
Date:_____Problem_____
Date:_____Problem_____

How would you rate your current sleeping habits? (Please circle or underline one)
Poor Unsatisfactory Satisfactory Good Very 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 problems:

_____

_____

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____

_____

What would you like to accomplish in therapy?

_____

_____

_____