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Teaneck, NJ 07666

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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 No

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?
