NEW CLIENT INTAKE QUESTIONAIRE

Name: _____

Name of Parent/Guardian (if under 18):_____

Birthdate:_____ Age:_____ Gender Identification: _____

Marital Status: _____

Please list any children/ages: _____

Have you received any mental health support in the past? Yes/No

If yes, please share the reasons for the visit and what may have been helpful or not helpful:

_____
_____
_____
_____

Please comment how you feel you are functioning in following life areas:

Appetite/Diet: (Concerns/No concerns)_____

Sleep: (Concerns/No concerns)_____

Family Relationships:(Concerns/No concerns)_____

Work/School Relationships: (Concerns/No concerns)_____

Have you experienced any significant life changes or stressors in the past 12 months? Yes/ No

If yes, please describe:_____

FAMILY MENTAL HEALTH

Alcohol/Substance Abuse or Addiction: Yes/No

Anxiety: Yes/No

Depression: Yes/No

Eating Disorder: Yes/No

Suicide Attempts: Yes/No

What do you hope to work on in your sessions?

_____
_____
_____
_____

Please add any further information you feel is important for the clinician to know to best support you:

_____
_____
_____
_____