Client Intake Information and Questionnaire

Sydney Isley, M.A., LMFT #88861
DBA Chino Valley Therapist

Please fill in the information below and bring it with you to your first session. Please note, information provided on this form is protected by your right to confidentiality and the psychotherapist-patient privilege.

Personal Information

Date: _____

Name: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: _____

May we leave a message? ☐ Yes ☐ No

Cell/Work/Other Phone: _____

May we leave a voicemail and/or text message? ☐ Yes ☐ No.

Email: _____

May we send a message? ☐ Yes ☐ No

Emergency Contact: _____

Emergency Contact Phone Number: _____

Please note: Email and texting correspondence is not considered to be a confidential medium of communication.

DOB: _____

Age: _____ Gender: _____

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Referred By (if any): _____

History

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

Please list current medications: _____

General and Mental Health Information

1. How would you rate your current physical health?
   (Please select 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 select one) ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

   Please list any specific sleep problems you are currently experiencing:

   _____

3. How many times per week do you generally exercise?

   _____

   What types of exercise do you participate in?

   _____

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

   _____

5. Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes

   Have you ever been hospitalized for psychiatric care? ☐ No ☐ Yes

   Are you feeling suicidal? ☐ No ☐ Yes

   If so, please describe any plans or means.

   _____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? ☐ No ☐ Yes

   If yes, when did you begin experiencing this?

   _____

7. Are you currently experiencing any chronic pain? ☐ No ☐ Yes

If yes, please describe your pain.

_____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. How often do you engage in recreational drug use?
   (Please select one) ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐ No ☐ Yes
    If yes, for how long? _____

    On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? 1

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

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)
Please select one and list family member.

Alcohol/Substance Abuse	☐ No ☐ Yes
Anxiety	☐ No ☐ Yes
Depression	☐ No ☐ Yes
Domestic Violence	☐ No ☐ Yes
Eating Disorders	☐ No ☐ Yes
Obesity	☐ No ☐ Yes
Obsessive Compulsive Behavior	☐ No ☐ Yes
Schizophrenia	☐ No ☐ Yes
Suicide Attempts	☐ No ☐ Yes

Additional Information

1. Are you currently employed? ☐ No ☐ Yes

   If yes, what is your current employment situation?

   _____

   Do you enjoy your work? Is there anything stressful about your current work?

   _____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

   If yes, describe your faith or belief:

   _____

3. What do you consider to be some of your strengths?

   _____

4. What do you consider to be some of your weaknesses?

   _____

5. What would you like to accomplish out of your time in therapy?

   _____