**Client Intake Questionnaire**

Kelli Olds LMFT #98178

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

**Personal Information**

Name:_____

Date:_____

Parent/Legal Guardian (if under18): _____

Address: _____

Home Phone: _____
Cell/Work/Other Phone: _____
Email: _____
DOB: _____ Age: _____ Gender: _____

Martial Status:

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

Referred By (if any): _____

Emergency Contact Person (Name/Relationship/Phone Number)

_____

**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
If yes, please list and provide dates:

_____
_____

Have you ever experienced suicidal thoughts? If yes, please describe.

_____
_____
_____

**General and Mental Health Information**

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:

_____
_____

May we leave a voice message? □ Yes □ No

May we leave a text message? □ Yes □ No

How would you rate your current sleeping habits? (Please circle one)
Poor Unsatisfactory Satisfactory Good Very good

Are you are currently experiencing any specific sleep problems? Please describe:

_____
_____

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:

_____
_____

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

If yes, for approximately how long?_____

Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this?

_____

Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe:

_____

Do you drink alcohol more than once a week? □ No □ Yes

How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently

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?

_____

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

_____
_____
_____

**Family Mental Health History**

Do you have a family history of any of the following? If yes, please indicate the family member's relationship to you.

Alcohol/Substance Abuse

Anxiety

Schizophrenia

Suicide Attempts

Depression

Obesity

Obsessive Compulsive Behavior

Eating Disorders

Domestic Violence

**Additional Information**

Are you currently employed?

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If yes, what is your current employment situation?

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

Do you consider yourself to be spiritual or religious? □ No □ Yes

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

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