703 Broad Street, Suite 205
Shrewsbury, NJ 07702
(732) 268-7968
Fax (732) 224-7607

Client Intake Questionnaire

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: _____

Parents/Legal Guardians (if under 18): _____

Address: _____

Home Phone: _____ May we leave a message? ▫ Yes ▫ No

Cell/Work/Phone: _____ May we leave a message? ▫ Yes ▫ No

Email: _____ May we leave a message? ▫ Yes ▫ No

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

Would you prefer appointment reminders to be sent via Email, text or both (circle one)

DOB: _____ Age: _____ Gender: _____

Martial Status:

▫ Never Married	▫ Domestic Partnership	▫ Married
▫ Separated	▫ Divorced	▫ Widowed

Referred By (if any): _____

Emergency Contact: _____ Relationship to client: _____

Address: _____

Phone Number: _____

History

Primary language spoken: _____

Highest level of Education: _____

Number of siblings: _____ Number of children: _____ Number of time custodial arrangements have changed in the last three years: _____

History of eating disorders: ▫ Yes ▫ No If yes, please list:

_____

Are there weapons in the home? ▫ Yes ▫ No If yes, please list:

_____

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:

_____

_____

Birth Information

▫ was born with no apparent complications
▫ was born premature
▫ weighed less than 5 1/2 pounds at birth
▫ spent time in a neonatal intensive care unit
▫ required assistance with breathing
▫ was born past due date
▫ other_____

Developmental Milestones

Please Check to the best of your ability that answer that applies:

	Early	Average	Late	Unknown
Sitting alone				
Crawling				
Standing alone				
Walking alone				
Speaking first words				
Speaking short sentence				
Eating solids				
Self-feeding				
Using toilet when awake				
Staying dry at night				
Social interaction				
Other				

General and Mental Health Information

1. 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: _____

_____

2. How would you rate your current sleeping habits? (Please circle 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

If yes, for approximately how long?_____

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: _____

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

9. How often do you engage in recreational drug use?

▫ 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? _____

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

_____

Personal Mental Health History

In the section below identify if there is a personal history of any of the following:

	Please Circle	Year started /Year Ended/Current
Alcohol/substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Bipolar Disorder	yes / no	_____
Eating Disorders:	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

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 Circle	List Family Member
Alcohol/substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Bipolar Disorder	yes / no	_____
Eating Disorders:	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____
Completed Suicide *(family member)*	yes / no	_____

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? _____