

Client Intake Questionnaire

Please fill in the information below and either e-mail it to tamie560@gmail.com or bring it with you to your first session.

Please note: information provided on this form is protected as confidential information.

Personal Information

Name: _____ Date: _____

Address: _____

Home Phone: _____

Cell/Work/Other Phone: _____

May I leave a message when trying to reach you: yes/no

Email: _____

DOB: _____ Age: _____ Gender: _____

Relationship Status: _____

Do you have children? If so, please list names and ages

People you currently reside with (Names and Relationship)

Emergency Contact (Name, Relationship and phone number)

Permission to call in case of emergency (Please sign and date)

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:

Are you currently experiencing any health problems? If so, please describe.

Please list any history hospitalizations

Please briefly describe your reasons for seeking psychotherapy and/or your goals for therapy:

Thank-you!