One to One Counseling & Consulting, PLLC

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: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

_____

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

Cell/Work/Other: _____ 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

Date of Birth: _____ 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 medication? ☐ No ☐ Yes, please list _____

_____

Are you currently taking prescription medications? ☐ No ☐ Yes, please list _____

_____

General and Mental Health Information

1. How would you rate your current physical health? (please check one)
   ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good
2. How would you rate your current sleeping habits?
   ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good
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: _____

   _____

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5. Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes
   If yes, when did you begin experiencing this? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ No ☐ Yes
   If yes, when did you begin experiencing this? _____

7. Are you experiencing any chronic pain? ☐ No ☐ Yes
   If yes, when did you begin experiencing this? _____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes
   If yes, how much? _____

9. Do you engage in recreational drug use? ☐ No ☐ Yes
   If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you 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? _____

_____

_____

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 Check	List Family Member
Alcohol/Substance abuse	☐ No ☐ Yes	_____
Anxiety	☐ No ☐ Yes	_____
Depression	☐ No ☐ Yes	_____
Domestic Violence	☐ No ☐ Yes	_____
Eating Disorder	☐ No ☐ Yes	_____
Obesity	☐ No ☐ Yes	_____
Obsessive Compulsive Disorder	☐ No ☐ Yes	_____
Schizophrenia	☐ No ☐ Yes	_____
Suicide Attempts	☐ No ☐ Yes	_____

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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 in therapy? _____

   _____

   _____

6. Any other information you would like us to know? _____

   _____

   _____

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