Client Intake Questionnaire

STILL WATERS COUNSELING HI LLC

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 I leave a message/text? □ Yes □ No

Cell/Work/Other Phone: _____May I leave a message/text? □ Yes □ No

Email: _____ May I leave a message? □ Yes □ No
**Please note: Email correspondence and text messaging are not considered to be confidential forms 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
If yes, please list and provide dates:

_____ _____
_____ _____

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? (Please circle one)

0x 1-2x 2-3x 3-4x 4-5x 5-6x everyday

What types of exercise do you participate in? (Please circle as many as applies)

Yoga Walking Running (Jogging) Team Sports Extreme Sports Other_____

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?
_____
_____

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.)

History of:	Please Circle	Family Member
Alcohol/Substance Abuse	Yes/No	
Anxiety	Yes/No	
Depression	Yes/No	
Domestic Violence	Yes/No	
Eating Disorders	Yes/No	
Obesity	Yes/No	
Obsessive Compulsive Behavior	Yes/No	
Schizophrenia	Yes/No	
Suicide Attempt	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? _____
_____
_____
_____
_____

Emergency Contact: _____ _____

Relationship

Cell Phone # _____ Home Phone # _____