Transformative Vision

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: _____
Preferred Name:_____Pronouns:_____
Parent/Legal Guardian (if under 18): _____
Address: _____
Home Phone: ___ _____ May we leave a message? □ Yes □ No
Cell/Work/Other 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.*
DOB: _____ Age: _____ Gender: _____
Martial 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. Do you have a Primary Care Physician or facility? □ Yes □ No
If yes, please list name, address and date of last appointment:
_____
_____

3. 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:
_____
_____
_____
_____

4. How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____
_____
_____

5. Please list any difficulties you experience with your appetite or eating problems: _____
_____
_____
_____

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

If yes, for approximately how long?_____

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

If yes, when did you begin experiencing this? _____

8. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

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

10. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

11. 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?
_____

12. 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. mother, father, grandmother, brother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no / unknown	_____
Anxiety	yes / no / unknown	_____
Depression	yes / no / unknown	_____
Domestic Violence	yes / no / unknown	_____
Eating Disorders	yes / no / unknown	_____
Obesity	yes / no / unknown	_____
Obsessive Compulsive Behavior	yes / no / unknown	_____
Schizophrenia	yes / no / unknown	_____
Suicide Attempts	yes / no / unknown	_____

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? _____
_____
_____