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? □ No □ Yes

Cell/Work/Other Phone: ____________ May we leave a message? □ No □ Yes
Email: ____
*Please note: Email and text 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

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner and dates:
____
____
____

2. Are you currently taking any prescription medication? □ Yes □ No
If yes, please list diagnosis, medication, and provide dates:

____
____
____
____

3. Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list diagnosis, medication, and provide dates:

____
____
____
____

General and Mental Health Information

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

If yes, how often and how much?

____

2. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently

If yes, which drugs do you use recreationally?

____

3. Do you have a history of suicidal ideation or suicide attempts? □ No □ Yes

If yes, please list dates and describe circumstances

____
____
____

4. Are you currently experiencing suicidal thoughts? □ No □ Yes

5. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

____

6. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

____

7. What would you like to accomplish out of your time in therapy?

____

____

____

Signature___________________________________ Date_____________________

Alison Dickson, MS, LMFT

Licensed Marriage and Family Therapist

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