Client Interview

Please fill out the information to the best of your ability and **bring it to your first session.**

The information you provide here is CONFIDENTIAL.

Name ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____
(Last) (First) (Middle Initial)

Birth Date**:** ______/________/_______ Age: ________

Gender: ________________________ Preferred Pronoun: _______

Sexual orientation: ____

Current Relationship Status (check all that apply):

___ Never Married ___ Domestic Partnership ___ Married ___ Separated

___ Divorced ___ Widowed

Number of pregnancies: ______

Please list any children and their ages: ____

____

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?

___ No

___ Yes Please list and provide dates: ____

____

General Health Information

1. How would you rate your current physical health? (Please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

2. How would you rate your current sleeping habits? (Please circle)

   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? ____________

   What types of exercise do you participate in? ____

4. Please list any difficulties you experience with your appetite or eating patterns:

____

5. Are you currently experiencing overwhelming sadness, grief, or depression?

___ No

___ Yes For how long? ______________

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

___ No

___ Yes When did you begin experiencing this? ____

7. Are you currently experiencing any chronic pain?

___ No

___ Yes Please describe ____

8. Do you drink alcohol more than once a week?

___ No

___ Yes How often? ____

9. How often do you engage in recreational drug use?

___ Daily ___Weekly ___ Monthly ___ Frequently ___ Never

10. What significant life changes or stressful events have you experienced recently?

____

____

____

____

Family Mental Health History

In the section below, please 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 (father, grandmother, uncle, etc.).

	Please Circle	**List 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 Disorde4r	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempts	Yes / No	

Additional Information

1. Are you currently employed?

   ___ No

   ___ Yes What is your current employment situation: ____

   ____

   Do you enjoy your work? Is there anything stressful about your current work? ________________________

   ____

   ____

2. Are you currently in a romantic relationship?

   ___ No

   ___ Yes How long? ________________

   On a scale of 1-10, how would you rate your relationship? ____________________

3. Do you consider yourself to be spiritual or religious?

   ___ No

   ___ Yes Describe your faith or belief ____

4. What do you consider to be some of your strengths?

   ____

   ____

   ____

   ____

5. What do you consider to be areas that need improvement?

   ____

   ____

   ____

   ____

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

   ____

   ____

   ____