Yvonne M Callaghan, LMFT

6304 Hardwood Lane
Cicero, NY 13039 * 315-944-5551

Client Intake Questionnaire

Please provide the following information and answer the questions below. Please note: the information you provide here is protected as confidential.

Please fill out this form and bring it to your first session.

Name:_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years)

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender:_____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced
□ Widowed

Please list any children/age:_____

_____

Address:_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____May we leave a VM or text message? □ Yes □ No

Cell/Other Phone:_____May we leave a VM or text message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: **Email correspondence is not considered to be a confidential medium of communication.**

Referred by (if any):_____

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

□ No □ Yes, previous therapist/practitioner:_____

Are you currently taking any prescription medication? □ Yes □ No

Please list:_____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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

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)

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 to you participate in _____

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

_____

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

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or 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 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, 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 for any of the following. If you answer 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	_____
Violence	yes/no	_____
Eating Disorders	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	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 flaws?

_____

_____

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

_____

_____

_____