Yvonne M Callaghan, LMFT
6221 State Route 31, Suite 106,
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 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?