

**CLIENT INTAKE QUESTIONNAIRE**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ M/F DOB \_\_\_\_\_ SINGLE/MARRIED/DIVORCED # CHILDREN \_\_\_\_\_

ADDRESS, CITY, ZIP: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PRIMARY & EMERGENCY PHONE #s: \_\_\_\_\_

WHO DO YOU LIVE WITH(NAME/AGE/RELATIONSHIP)? \_\_\_\_\_

WHAT BROUGHT YOU TO THERAPY TODAY?

WHAT IS YOUR PRIMARY GOAL FOR THERAPY? \_\_\_\_\_

1. During the last 2 weeks, how often have you been bothered by:	None	Some Days	1/2+ Days	Most Days
a. Little interest or pleasure in doing things.....	___	___	___	___
b. Feeling down, depressed, or hopeless .....	___	___	___	___
c. Trouble falling/staying asleep, or sleeping too much .....	___	___	___	___
d. Feeling tired or having little energy .....	___	___	___	___
e. Poor appetite or overeating .....	___	___	___	___
f. Feeling bad about yourself – that you are a failure or have let close others down .....	___	___	___	___
g. Trouble concentrating on things such as reading or watching TV.....	___	___	___	___
h. Moving/speaking slowly/fast enough for others to notice .....	___	___	___	___
i. Thoughts that you would be better off dead or of hurting yourself .....	___	___	NO	YES
2. In the last 4 weeks have you had an anxiety attack, sudden fear or panic? .....			___	___
a. Has this ever happened before?.....			___	___
b. Do some of these attacks come on suddenly and unexpectedly?.....			___	___
c. Do attacks bother you a lot or do you worry about having another attack? .....			___	___
d. Did your heart race, pound, skip, or have chest pain/pressure? .....			___	___
e. Did you sweat, feel as if your were choking/dying? .....			___	___
3. Questions about eating			NO	YES
a. Do you often feel you can't control what or how much you eat? .....			___	___
b. Do you often eat, within 2 hours, an unusually large amount of food? .....			___	___
c. Have "a" and "b" occurred an average of 2 times a week for the last 3 months? .....			___	___
4. In the last 3 months have you often done any of the following to avoid weight gain?			NO	YES
a. Vomitted, taken 2x/dose of laxatives, not eaten for 24 hours? .....			___	___
b. Exercised 1-hour or more to avoid weight gain after eating a large amount of food? .....			___	___
c. If you marked "YES" did you do any of these an average of twice a week? .....			___	___
5. Do you ever drink alcohol? (If no skip to #7) .....			___	___
6. Have you done the following 1+ times in the last 6 months?				
a. You drank alcohol even though there is a problem with your health .....			___	___
b. You drank alcohol, were high/hung over while working/in school/caring for children .....			___	___
c. You were late for work/school/activities because of drinking .....			___	___
d. You had conflicts with others while drinking .....			___	___
e. You drove after having several/too much drinks .....			___	___
7. In the previous year have you been physically hurt by someone or forced into a sexual act? [Circle].....			NO	YES
8. Are/have you taking(en) any medicine for a mental disorder? If so, what? _____			NO	YES