MIND MULTITUDES
MENTAL HEALTH & WELLNESS CLINIC

# 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? □ Yes □ No
Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No
Email: _____ May we leave a message? □ Yes □ No
DOB: _____ Age: _____ Gender: _____
Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Referred by (if any): _____

Additional information:_____

## Health and Medical History

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

_____

List medical conditions and diagnoses if applicable: _____

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No
If yes, please list:

_____
_____

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

## General and Mental Health Information

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

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 one)

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? If yes, what types of exercise do you participate in?

4. Please indicate any difficulties you experience with your appetite or eating problems:

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

   If yes, for approximately how long?

6. Are you currently experiencing anxiety, panics attacks or have 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 in recreational drug use?
   □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Have you experienced any suicide ideation or self-harming attempts? If yes, indicate the last time you experienced this.

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

12. In addition to counselling practices we offer in-person one-on-one meditation practice. Would you be interested in participating in mindfulness meditation classes or restorative yoga? If yes, how many times per week?

## Family Mental Health History

In the section below, 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 (e.g. 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 Behavior | yes / no | _____ |
| Schizophrenia | yes / no | _____ |
| Suicide Attempts | yes / no | _____ |

## Additional Information

Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses

On a scale from 0-10 how confident are you with yourself? (0 is none – 10 is the highest)

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

Please indicate if there is anything you would like us to know to help serve you better.