

Client Questionnaire and Intake

Please note: information provided on this form is protected as confidential information. Please bring with you for our first visit.

Intake Date _____

Name _____ DOB _____

Address _____

Phone _____ email _____

Employer _____

Occupation _____

School _____ Grade _____

Circle one or more: M F NB L G B T Q I A Pronoun(s): _____

Chosen Name: _____

Family History

Married _____ Divorced _____ Date of Divorce _____

Partner's name _____

Children's Names _____ Ages _____

Parents' Names _____

Medical History

Personal Physician/Psychiatrist _____

Current Medications and Dosages _____

Current Non Prescription Drug Use _____

Have you been in psychotherapy before? _____

What would you like to achieve from therapy? _____