



Client Intake Questionnaire

Please fill in the information below and provide the completed form no less than 72-hours prior 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 I leave a message? Yes No

Cell/Work/Cell/Work/Another Phone: _____ May I leave a message? Yes No

Email: _____ May I leave a message? Yes No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: _____ Age: _____ Identified Gender: _____

Marital Status:

- Never Married Domestic Partnership Married
 Separated Divorced Widowed

Referred By (if any): _____

History

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

No Yes, previous therapist/practitioner: _____

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

W. Allen Pittinger-Dunham, MSW, LICSW, CAC-II, MAC
Telephone: (240) 339-4196

www.ssop.lgbt

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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? _____

What types of exercise do you participate in? _____

4. Please list 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

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10. Are you currently in a romantic relationship? No Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), 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 of any of the following. If yes, please indicate the family member's relationship to you in the space.

| | 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

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? _____

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4. What do you consider to be some of your barriers that prevent you from being the individual you want to be?

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

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