

Client Intake Questionnaire

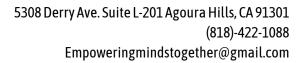
Please fill in the information below and email to *Empoweringmindstogether@gmail.com* Please note: information provided on this form is protected as confidential information.

Personal Information

Name:		Date:
Parent/Legal Guardian (if under 18):		
Address:	City:	Zip:
Home Phone:		May we leave a message? ☐ Yes ☐ No
Cell/Work/OtherPhone:		May we leave a message? ☐ Yes ☐ No
Email:		May we leave a message? \square Yes \square No
DOB:	Age:	Gender:
Marital Status:		
☐ Never Married ☐ Domestic F	Partnership □ Married □ \	Widowed □ Separated □ Divorced
	Emergency Contac	ct
Name:	Phone Num	aber:
Address:		
Relation to Patient:		



History	
Have you previously received any type of mental health services? ☐ No ☐ Yes	
Previous Psychiatrist/Therapist/Practitioner:	
Are you currently taking any prescription medication? ☐ No ☐ Yes	
If yes, please list:	
Have you ever been prescribed psychiatric medication? ☐ No ☐ Yes	
If yes, please list and provide dates:	
General and Mental Health Information	
1. How would you rate your current physical health? (Please check 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?	
☐ 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				
10. Are you currently in a romantic relationship? ☐ No ☐ Yes				



Suicide Attempts

If yes, for how long?				
On a scale of 1-10 (with 1 being poor a	and 10 being	exceptional),	how would you rate your relationship?	
	5 🗆 6	□ 7 □	8 🗆 9 🗆 10	
II. What significant life changes or stre	essful events	have you exp	erienced recently?	
Fam	ily Menta	al Health	History	
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	a family histo	ry of any of th	e following. If yes, please indicate the fami	ily
In the section below, identify if there is a	a family histo ce provided (ry of any of th	e following. If yes, please indicate the fami	ily
In the section below, identify if there is a	a family histo ce provided (ry of any of th e.g. father, gr	e following. If yes, please indicate the fami andmother, uncle, etc.)	illy
In the section below, identify if there is a member's relationship to you in the space	a family histo ce provided (Please	ery of any of the fe.g. father, grants	e following. If yes, please indicate the fami andmother, uncle, etc.)	illy
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In the section below, identify if there is a member's relationship to you in the space Alcohol/Substance Abuse Anxiety	a family histoce provided (Please No	ery of any of the fe.g. father, grade Check Yes Yes	e following. If yes, please indicate the fami andmother, uncle, etc.)	illy
In the section below, identify if there is a member's relationship to you in the space. Alcohol/Substance Abuse Anxiety Bipolar	a family histoce provided (Please No No	ery of any of the fe.g. father, grade Check Yes Yes Yes	e following. If yes, please indicate the fami andmother, uncle, etc.)	illy
In the section below, identify if there is a member's relationship to you in the space. Alcohol/Substance Abuse Anxiety Bipolar Depression	a family histoce provided (Please No No No	ry of any of the e.g. father, grade Check Yes Yes Yes Yes Yes	e following. If yes, please indicate the fami andmother, uncle, etc.)	illy
Alcohol/Substance Abuse Anxiety Bipolar Depression Domestic Violence	a family histoce provided (Please No No No No	ry of any of the e.g. father, grade Check Yes Yes Yes Yes Yes Yes	e following. If yes, please indicate the fami andmother, uncle, etc.)	illy
Alcohol/Substance Abuse Anxiety Bipolar Depression Domestic Violence Eating Disorders	a family histoce provided (Please No No No No No	ry of any of the e.g. father, grade Check Yes Yes Yes Yes Yes Yes Yes Yes	e following. If yes, please indicate the fami andmother, uncle, etc.)	iily

☐ No

☐ Yes



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?
3. What do you consider to be some or your strengths:
4. What do you consider to be some of your weaknesses?
5. What would you like to accomplish out of your time in therapy?



Relation to patient:

Insurance / Payment Information

Please Note: Empowering Minds Together, Inc. files insurance as a courtesy to you, and you, not your insurance company are ultimately responsible for your bill. Please expect to pay your portion of copay, coinsurance, deductible, or self-pay payments at the time of service and carefully review our Terms of Service document for more information regarding our cancellation policy/fees. Self-Pay: □ No ☐ Yes Member ID: Primary Insurance: Secondary Insurance: Member ID: Referral Source (if any): If not, how did you hear about us: Disclosure and Consent for Treatment **Confidentiality and Terms of Service** In general, we must have your written release to provide information to others. Please see our *Privacy Policy* and *Terms of Service* documents for exceptions and for more information. **Patient Acknowledgment** By my signature, I acknowledge Empowering Minds Together, Inc. has made *Privacy Policy* and *Terms of* Service documents available. I, the undersigned, have reviewed all documents and consent to treatment. I, the undersigned, hereby authorize Empowering Minds Together, Inc. and/or it's staff to the extent required to assure payment to disclose any diagnosis and pertinent treatment information to a designated person, corporation, government agency or third party payer in order to receive payment for services rendered. Patient Name (print): Patient or legally authorized individual signature:

Please email completed form to Empoweringmindstogether@gmail.com

Date: