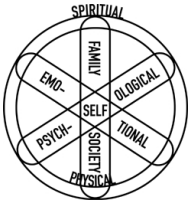

Family Therapy Center of Old Town
401 S. Washington Street
Alexandria, VA 22314

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

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 current or past health problems:_____
_____

Office: (703) 549-3881 Fax: (703) 549-2427 Email: familytherapycenterofoldtown@gmail.com
Website: familytherapycenterofoldtown.com

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:_____

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
If yes, how often?_____

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
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?_____

Please continue to the next page.

Family Medical and Mental Health History

1. Do you have a family history of any illnesses and/or chronic conditions? □ No □ Yes
If yes, please list the family member and illness/condition:_____

_____

2. 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	
Bipolar Disorder	Yes / No	
Suicide Attempts	Yes / No	
ADHD	Yes / No	
Obsessive Compulsive Behavior	Yes / No	
Schizophrenia	Yes / No	
Eating Disorders	Yes / No	
Obesity	Yes / No	
Domestic Violence	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?_____

_____

_____

4. What do you consider to be some of your areas to improve?_____

_____

_____

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

_____

_____