Sandra J. Preciado, Psy.D.
Private Practice

CLIENT INTAKE QUESTIONNAIRE

Please complete the information below. Information provided on this form is protected as confidential information and will not be shared without your consent.

Name: _____ Date:_____

Parent/Legal Guardian [if under 18]: _____

Social Security Number: _____ Driver's License: _____

Address:_____

Home Phone: _____ May I leave a message ? Yes __ No__

Cell/Work Phone: _____ May I leave a message ? Yes __ No__

Email: _____ May I leave a message ? Yes __ No__

Please note, email is not considered to be a confidential medium of communication.

Date of Birth: _____ Age: _____ Gender: _____

Marital Status: (Please Circle One)

Never Married / Married / Domestic Partnership / Widowed / Separated / Divorced

Referred By: _____

HISTORY

Have you previously received any type of mental health services? Yes ____ No ____

If Yes, Please list types of services: _____

Did you find these services helpful? Yes _____ No _____

Have you ever been prescribed psychotropic medications? Yes / No

If yes, please list the names of the medications: _____

_____

Are you currently taking any medications? Yes / No

If yes, please list the names of the medications: _____

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General and Mental Health Information

How would you rate your current:

Physical Health:

Poor Unsatisfactory Satisfactory Good Very Good

Have you been diagnosed with a medical condition(s) or have any health concerns?

Yes / No If Yes, please explain: _____

Eating Habits:

Poor Unsatisfactory Satisfactory Good Very Good

Please list any difficulties with your appetite or digestive problems:

_____

Sleeping Habits:

Poor Unsatisfactory Satisfactory Good Very Good

Have you been diagnosed with a sleeping disorder/experience difficulty sleeping?

Yes / No If Yes, please explain _____

How many hours of sleep do you get each night? _____ Do you wake rested? Y / N

Physical Activities/Exercise:

How many times per week do you engage in physical activities?

___1-2 ___ 3-5 __ 5 or more What types of activities? _____

Are you experiencing any form of chronic pain/injuries? Y / N

_____

Are you currently experiencing overwhelming sadness, grief, or depression? Y / N

If yes, how long? _____ Have you ever experienced suicidal thoughts? Y / N

Are you currently experiencing anxiety, panic attacks or phobias? Y / N

If yes, please explain: _____

When did this start? _____ How often? _____

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How often do you drink alcohol?
Daily / Weekly / Monthly / Infrequent / Never

How often do you engage in recreational drug use?
Daily / Weekly / Monthly / Infrequent / Never

Are you currently in a romantic relationship? Y / N
Based on your response, how satisfied are you?
Not Satisfied / Indifferent / Very Satisfied

What significant life changes or stressful events have you experienced:

Recently: _____

Life Time: _____

Family Mental Health History

Please list a family member with history in the corresponding section, such as mother, father, sister, uncle, etc.

Alcohol/Substance Abuse _____
Anxiety _____
Depression _____
Eating Disorders _____
Obesity _____
Schizophrenia _____
Bipolar Disorder _____
Suicide Attempts _____
Domestic Violence _____
Other: _____ _____

Comments: _____

Medical and Referral Information

Name of Primary Care Physician: _____

Location: _____Phone Number: _____

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Additional Information

Are you currently employed? Y / N

If yes, what is your occupation? _____

Do you enjoy your work? If no, please list stressors or dissatisfaction related to your work:

_____

_____

Do you consider yourself spiritual or religious? _____

If religious, what is your faith or belief? _____

What do you consider to be your strengths? _____

_____

What do you consider some of your weakness? _____

_____

List three top reasons you are seeking therapy:

1. _____
2. _____
3. _____

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

_____

_____

Emergency Contact Phone Number: _____

Name: _____ Relationship: _____

This questionnaire will be reviewed with you in session, it is simply to gather information for the purpose of making the most of your intake session.