Client Intake Questionnaire

Welcome to AutumnRX! Initiating therapy can feel intimidating, and I want to acknowledge the courage it takes to be here. Your responses will help me understand your background, concerns, and strengths, allowing us to work together towards balance and well-being. Please complete this form as thoroughly as you're comfortable with. Your answers to responses are confidential. This is just the first step in our journey together.

Basic Information

- **Today's Date: _____**
- **Full Name: _____**
- **Date of Birth: _____**
- **Address: _____**
- **Phone Number: _____**
- **Email: _____**
- **Preferred Contact Method (Phone/Email/Text): _____**
- **Highest Level of Education & Year Completed: _____**

Presenting Concerns & Goals

1. What are the main concerns that led you to seek therapy at this time?

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2. Have you received any mental health treatment in the past? If so, please describe (e.g., therapy, hospitalization, medications).

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3. What thoughts, feelings, or behaviors concern you? When did you first notice them?

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4. What are your goals for therapy? What would you like to achieve?

Medical & Mental Health Information

- **Current Medications (if any): _____**
- **Current Diagnoses (if any): _____**
- **Date of Diagnosis: _____**
- **Primary Care Physician or psychiatrist: _____**

History & Risk Factors

Please **circle** "Yes" or "No" for the following, then **circle** "Current" or "Past," and provide additional details where applicable:

- **Legal Issues:**
  - [ ] Yes [ ] No [ ] Current [ ] Past
  - If yes, please describe: _____

- **Substance Use:**
  - Alcohol use
    - [ ] Yes [ ] No [ ] Current [ ] Past
    - If yes, how many drinks per week? _____
  - Drug use
    - [ ] Yes [ ] No [ ] Current [ ] Past
    - If yes, how many drinks per week? _____

- **History of Abuse (Emotional/Physical/Sexual):**
  - [ ] Yes [ ] No [ ] Current [ ] Past
  - If yes, please describe: _____

- **Suicidal Thoughts:**
  - [ ] Yes [ ] No [ ] Current [ ] Past
  - If yes, please describe: _____

- **Suicide Attempts (If applicable, please list dates):**
  - [ ] Yes [ ] No [ ] Current [ ] Past
  - If yes, please describe: _____

- **Self-Injury:**
  - [ ] Yes [ ] No [ ] Current [ ] Past
  - If yes, please describe: _____

Eating Difficulties:

- [ ] Yes [ ] No [ ] Current [ ] Past
- If yes, please describe: _____

- **Have you experienced any significant challenges, losses, or traumatic events? If yes, please describe:**

Family & Support System

- **Family of Origin (List significant family members and your relationship to them):**

- **Current Family Members (Spouse, Children, Others in Household):**

- **Who in your life provides you with the most support?**

- **Do you have any current concerns about your safety or the safety of your loved ones?**
  - [ ]Yes [ ] No
  - If yes, please explain: _____

Identity & Strengths

8. Are there aspects of your identity (sexual, spiritual, ethnic, cultural, gender, etc.) that are important to you?

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9. What helps you cope during difficult times? (e.g., hobbies, meditation, exercise, social support)

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10. What do you consider your personal strengths?

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11. Have you been in therapy before? If so, what worked well for you?

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12. Is there anything else you'd like me to know that I haven't asked about?

Thank you for taking the time to complete this form. I look forward to working with you and supporting you on your journey.