Susan J. O'Grady, Ph.D.

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: _____
Address:_____
Phone: ___ _____ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No
Email: _____ May we send a message? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

DOB: _____ Age: _____ Gender: _____

Martial Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Referred By _____

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

- 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:
_____

- 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:
_____
_____

- How many times per week do you generally exercise?

  What types of exercise do you participate in? _____
  Please list any difficulties you experience with your appetite or eating problems:
  _____

- Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
  If yes, for approximately how
  long?_____

- Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
  If yes, when did you begin experiencing this?
  _____

- Are you currently experiencing any chronic pain? □ No □ Yes

  If yes, please describe: _____

- Do you drink alcohol more than once a week? □ No □ Yes

- How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

- Are you currently in a romantic relationship? □ No □ Yes

  If yes, for how long? _____

- What significant life changes or stressful events have you experienced recently?
  _____
  _____
  _____
  _____