exhale
HEALING ARTS LLC

800 Riverview Ave Suite 104
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www.exhalehealingartsllc.com

Dr. Phyllis Alongi PhD, LPC, ACS

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: _____Pronouns: _____

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/program: _____

Are you currently taking any prescription medication? □ Yes □ No
If yes, please list:

_____
Name and Location of Prescriber:

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:

_____

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Name and Location of Prescriber:
_____

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 health problems you are currently experiencing: _____
_____

Have you ever had surgery? □ No □ Yes
If yes, please list and provide dates: _____

2. How would you rate your current sleeping habits? (Please circle one)
Poor Unsatisfactory Satisfactory Good Very good

Do you have problems falling asleep and/or staying asleep? □ No □ Yes
Do you frequently have nightmares? □ No □ Yes □ Sometimes

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, panic 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: _____

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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
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? _____
_____
_____

Family Mental Health History

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 Disorders (i.e., OCD, panic attacks, etc.)	yes / no	_____
Depression	yes / no	_____
Domestic Violence or other traumas	yes / no	_____
Eating Disorders	yes / no	_____
Serious Mental Illness (i.e., Bipolar, Schizophrenia, etc.)	yes / no	_____
Suicide Attempts/or Completion	yes / no	_____

Additional Information

1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation? _____
_____

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Do you enjoy your work? Is there anything stressful about your current work? _____
_____
_____

2. Are you currently in school? □ No □ Yes

If yes:
Name of School: _____ Grade: _____-

Do you enjoy school? Is there anything stressful about school?
_____
_____

3. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief: _____
_____

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

5. What do you consider to be some of your weaknesses? _____
_____
_____
_____

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