Hope Rising
Health Services, LLC

282 E Main Street
Newark, DE 19711

Phone: 443-987-6557
Fax: 410-793-1599
www.hoperisinghs.com

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): _____
Full 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: _____
Preferred Pronouns: He/him Her/she They/them Other:
Martial 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

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Please list any specific health problems you are currently experiencing: _____
_____

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 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, 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

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? _____
_____
_____

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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	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders:	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	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 weaknesses? _____
_____
_____

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