Kimberly Pillsbury, MA, LPC, LCADC, ACS, NCC, LLC

Psychotherapist

316 Broad Street, Suite 4
Red Bank, NJ 07701
732-737-1224

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: ____

City: ____________________ State: _________ Zip Code: ____________

Home/Cell: ______________________ May we leave a message? ☐ Yes ☐ No

Work: ______________________ May we leave a message? ☐ Yes ☐ No

Email: ______________________ May we leave a message? ☐ Yes ☐ No

**Please note: Email and text correspondence is not considered a confidential medium of communication and are not HIPPA Compliant.*

I would prefer appointment reminders to be sent via: ☐ E-mail ☐ Text ☐ Both

DOB (MM/DD/YYYY): __________ Age: ______ Sexual Preference: ____________

Gender Identity: __________ Gender Pronouns: ________________

Martial Status:

☐ Never Married ☐ Domestic Partnership ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

Number and ages of children:

____

Referred By (if any): ______________________________________

Emergency Contact: __________________________ Relationship to client: _______________

Emergency Contact Phone Number: ____________________

Presenting problem and symptoms that brought you to counselor:

____

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

____

History

History of eating disorders: ◻ Yes ◻ No

If yes, please list: ____

Have you Been Hospitalized in Last 2 years for Mental Health? ◻ Yes ◻ No

If yes, please provide date, place, and reason: ____

Have you previously received any type of mental health Out Patient Services (psychotherapy, psychiatric services, etc.)?

◻ Yes ◻ No If yes, list previous therapist/practitioner: __________________________

If yes, do you wish me to connect with therapist/practitioner? ◻ Yes ◻ No

Are you currently taking any prescription medication? ◻ Yes ◻ No

If yes, please list and provide dates: ____

Have you ever been prescribed psychiatric medication? ◻ Yes ◻ No

If yes, please list and provide dates: ____

Family History

Number of siblings: ________ Ages of siblings: _______________________________________

Mother: ◻ Living ◻ Deceased ◻ I am her Caretaker
Father: ◻ Living ◻ Deceased ◻ I am his Caretaker

Parents are/were: ◻ Married ◻ Divorced ◻ Separated

If parents divorced or separated, what age were you when it happened? ____________

Do you have any step-parents? ◻ Yes ◻ No

General and Mental Health Information

How would you rate your current physical health?

◻ Poor ◻ Unsatisfactory ◻ Satisfactory ◻ Good ◻ Very good

Please list any specific health problems you are currently experiencing:

____

How would you rate your current sleeping habits?

◻ Poor ◻ Unsatisfactory ◻ Satisfactory ◻ Good ◻ Very good

Please list any specific symptoms, problems you are currently experiencing and indicate how long:

____

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? ◻ Yes ◻ No

If yes, please explain, and for approximately how long? ____________________

Are you currently experiencing anxiety, panics attacks or have any phobias? ◻ Yes ◻ No

If yes, when did you begin experiencing this? __________________________

Are you currently experiencing any chronic pain? ◻ Yes ◻ No

If yes, please describe: _______________________________________

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

If yes, how much alcohol do you drink in a week? ______________ Month: _____________

How often do you engage in recreational drug use?

◻ Daily ◻ Weekly ◻ Monthly ◻ Infrequently ◻ Never

Have you ever had treatment either inpatient or outpatient for substance abuse? ◻ Yes ◻ No

If yes, Please provide dates, facility, and circumstance leading up to treatment:

____

Are you currently in a romantic relationship? ◻ Yes ◻ No

If so for how long? ___________________

On a scale of 1-10 (1 being poor & 10 being great), how would you rate your relationship? ______

Personal Mental Health History

In the section below identify if there is a personal history of any of the following:

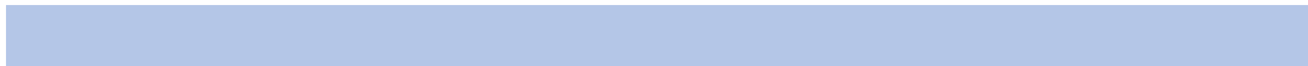
			Year started /Year Ended/Current
Alcohol/substance Abuse	☐ Yes	☐ No	___________________________
Anxiety	☐ Yes	☐ No	___________________________
Depression	☐ Yes	☐ No	___________________________
Domestic Violence	☐ Yes	☐ No	___________________________
Bipolar Disorder	☐ Yes	☐ No	___________________________
Eating Disorders:	☐ Yes	☐ No	___________________________
Obesity	☐ Yes	☐ No	___________________________
Obsessive Compulsive Behavior	☐ Yes	☐ No	___________________________
Schizophrenia	☐ Yes	☐ No	___________________________
Suicide Attempts	☐ Yes	☐ No	___________________________

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.)

			List Family Member
Alcohol/substance Abuse	☐ Yes	☐ No	______________________
Anxiety	☐ Yes	☐ No	______________________
Depression	☐ Yes	☐ No	______________________

Domestic Violence	☐ Yes	☐ No	____________________
Bipolar Disorder	☐ Yes	☐ No	____________________
Eating Disorders:	☐ Yes	☐ No	____________________
Obesity	☐ Yes	☐ No	____________________
Obsessive Compulsive Behavior	☐ Yes	☐ No	____________________
Schizophrenia	☐ Yes	☐ No	____________________
Suicide Attempts	☐ Yes	☐ No	____________________
Completed Suicide *(family member)*	☐ Yes	☐ No	____________________



Are you currently employed? ☐ Yes ☐ No

If yes, what is your current employment situation? ☐ Part-time ☐ Full-time

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

____

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

If yes, describe if and how you would want this to be incorporated into your therapy:

____

List what you consider to be some of your strengths?

____

List what you consider to be some of your weaknesses?

____

What are your goals for therapy?

____