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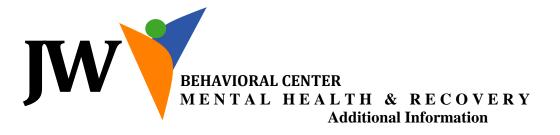
Client Intake Questionnaire

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? \square Yes \square No
Cell/Work/Other Phone:	May we leave a message? \square Yes \square No
Email:	May we leave a message? \square Yes \square No
*Please note: Email correspondence is not considere	ed to be a confidential medium of communication.
DOB: Age:	Gender:
Marital Status:	
\square Never Married \square Domestic Partnership \square Married	d
\square Separated \square Divorced \square Widowed	
Referred By (if any):	
Have you previously received any type of mental heal etc.)? \[\sum \text{No } \sum \text{Yes, previous therapist/practitioner:} \] Are you currently taking any prescription medication? If yes, please list:	? □ Yes □ No
Have you ever been prescribed psychiatric medication If yes, please list and provide dates:	1? □ Yes □ No
General and Mental 1. How would you rate your current physical health? (Pleas Poor Unsatisfactory Satisfactory Good	se circle one) Very good
Please list any specific health problems you are currently e	xperiencing:

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?	
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? \square No \square 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.)	
Alcohol/Substance Abuse Please Circle List Family Member yes / no	
Anxiety yes / no	-
Depression yes / no	
Domestic Violence yes / no	
Eating Disorders yes / no	
Obesity yes / no Obesity Compulsive Rehavior yes / no	
Obsessive Compulsive Behavior yes / noSchizophrenia yes / no	
Suicide Attempts yes / no	



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