

Client Intake Questionnaire

Client Name: _____ Date: _____

Instructions: Please rate yourself on a scale of 1-5 with 1 = no problem and 5 = severe problem, within the last six months. Then answer the questions below, using additional paper if necessary.

Sleeping Patterns:	1	2	3	4	5
Dream Patterns:	1	2	3	4	5
Eating Patterns:	1	2	3	4	5
Activity/Exercise Patterns:	1	2	3	4	5
Spiritual Practice:	1	2	3	4	5
Self-Care Patterns:	1	2	3	4	5
Sexual Activity/Lifestyle	1	2	3	4	5

Please describe any changes in sleeping patterns, such as trouble falling asleep, waking up during the night, or dream changes:

Please describe the last dream you remember:

Please describe any changes in eating patterns, such as increase or loss of appetite, nervous or emotional eating, and eating because of stress:

Please describe any changes in daily activities or exercise habits, such as beginning or stopping a routine:

Please describe your spiritual practice(s):

Please describe how you take care of yourself:

Please describe how you feel about your sex life and any issues that are of concern to you: