



Client Intake Checklist

To help make sure we cover any concerns you may have, please select (write your answer if a blank is provided) to each questions below. Thank you for your cooperation.

Are you having difficulty sleeping? Yes No

How many hours do you sleep each night? _____

How would you describe your energy level? Poor Fair Good Excellent

Have you had changes in your appetite? Yes No

How would you describe your eating habits? Poor Fair Good Excellent

Have you or others been concerns about your weight? Yes No

Do you have concerns about your physical health? Yes No

Do any family members have alcohol or drug problems? Yes No

Do you have sexual concerns? Yes No

Do you have any thoughts/plans about hurting yourself? Yes No

Do you have any thoughts/plan about hurting others? Yes No

Do you feel you are in danger of being hurt? Yes No

Has your living situation changed in the last two years? Yes No

How long have you lived at your present location? _____

Are you living alone? Yes No

Do you find it hard to talk about personal problems with others? Yes No

Do you have problems in your relationship or with other people? Yes No

Do you prefer not to participate in community or social activities? Yes No

Have you changed jobs in the last two years? Yes No

Do you like your job? Yes No

Have you been having problems with coworkers? Yes No

Do you have legal problems? Yes No

Are you having financial problems? Yes No

Have you lost faith in a higher power? Yes No

Have you lost hope your problems can be resolved? Yes No

Have you ever been in counseling? Yes No

1970 Oakcrest Ave. Suite 200 Roseville, MN 55113
2002 London Rd. Suite 95 Duluth, MN 55812
10761 Virginia Plaza Suite 103 Papillion, NE 68128
N25W23055 Paul Rd. #3 Pewaukee, WI 53072
www.team-mn.com | 651.642.0182 800.634.7710