Client Intake Questionnaire

Name:
Date of Birth:
Today's Date:
Preferred Name / Pronouns:

What brings you here today? (top 2–3 concerns in your own words)

How long have these been affecting you?

What do you hope will change through our work together?

How did you hear about the Integrative Psychiatry Service?

Are you interested in treatment for your general health or for a specific condition, or both?

Have you ever worked with a psychiatrist, therapist, or coach before? □ Yes □ No

If yes, what was most / least helpful?

Do you feel you are currently in a crisis?

> If yes, what kind of crisis?
>
> Are you worried you might lose control and harm yourself or someone else?
>
> Are you having any experiences like hearing voices or seeing visions that other people are not aware of?

Have you ever been psychiatrically hospitalized?

What psychiatric conditions have you been treated for?

Current medications (psychiatric and other):

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Current supplements/herbs:

Allergies:

Medical conditions (e.g., thyroid, autoimmune, neurological, chronic illness):

Sleep: average hours/night _____ Quality □ Poor □ Fair □ Good

Exercise/movement:

Diet/food pattern:

Substance use (alcohol, nicotine, cannabis, caffeine, others):

Do you have your own primary care provider (PCP)?

What are your goals and/or expectations?

Do you feel you are currently in a crisis?

If yes, what kind of crisis?

Are you worried you might lose control and harm yourself or someone else?

Are you having any experiences like hearing voices or seeing visions that other people are not aware of?

Do you have any current safety concerns (self-harm, violence, housing, etc.)?

□ Yes □ No

Have you ever been psychiatrically hospitalized?

What psychiatric conditions have you been treated for?

Do you now, or have you ever, used substances of abuse? If yes, which ones, for how long?

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Occupation / daily role(s):

Living situation:

Significant relationships (partner, children, close family/friends):

Spirituality / worldview (optional):

What lifestyle factors do you believe most affect your mood or energy (e.g., diet, sleep, stress, movement)?

Do you have recent lab work? □ Yes □ No If yes, please attach.

Are you interested in nutrition, supplements, or functional medicine as part of your care?
□ Yes □ No □ Unsure

What strengths or skills do you want to build on?

Where do you feel stuck or blocked right now?

What personal/professional goals are most important to you in the next 6–12 months?

How would your life look different if this work were successful?

Have you had prior psychedelic experiences you'd like to process? □ Yes □ No

Are you considering psychedelic therapy or retreat settings in the future? □ Yes □ No □ Unsure

What would you like support with (e.g., making meaning, grounding insights, daily application)?

Anything you would like to add?

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Signature: _____ Date: _____