Intake Form

Please complete and bring this form with you to your first session. Information collected on this form is treated as confidential.

Name: ____
(First) (Last)

Name of parent/guardian (if under 18 years):

____
(First) (Last)

Birth Date: ______ /______ /______ Age: ________ Gender: ____________________

Address: ____

____

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

Emergency Contact Person:_________________________________Phone:____________________

I was referred by (if applicable):____

May we email you? □ Yes □ No

If yes, please provide email address: ____

**(Please note: Email is not considered to be a confidential form of communication.) **

HEALTH INFORMATION

Note: Some counselling issues are clinical (needing medical or psychiatric attention). In such circumstances, I will request that you will seek the additional support of a doctor, a psychiatrist, or a psychologist to work with you on these issues.

Physician's Name: ____

Phone Number: ____

Medication (Prescription and non-prescription, please provide dosage)

____

____

Approximate Date of Last Physical Exam: ____

How would you rate your current physical health? (please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any current health concerns:

____

____

How would you rate your current sleeping habits? (please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please describe any specific sleep problems you are currently experiencing:________________

____

What type(s) of exercise to you participate in and how often?

____

____

Please list any difficulties you are experiencing with your appetite or eating patterns.

____

____

Are you currently experiencing sadness, grief or depression? ☐ No ☐ Yes

If yes, for approximately how long**?** ____

Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ No ☐ Yes

If yes, when did you begin experiencing this? ___________________________________

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

If yes, please describe ____

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

Do you engage recreational drug use? If so, how often?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently

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

Please list and provide approximate dates: ____

FAMILY MENTAL HEALTH HISTORY:

Please 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 (father, grandmother, uncle, etc.).

		Family Member
Alcohol/Substance Abuse	☐	______________________________
Anxiety	☐	______________________________
Depression	☐	______________________________
Domestic Violence	☐	______________________________
Eating Disorders	☐	______________________________
Obsessive Compulsive Behavior	☐	______________________________
Suicide Attempt(s)	☐	______________________________
Other Mental Health Issue(s)	☐	______________________________

RELATIONSHIP STATUS

Please indicate which of the following best describes your relationship status:

□ Partnership □ Married □ Separated □ Never Married □ Divorced □ Widowed □ Single

On a scale of 1 – 10 (1 low, 10 high) how satisfied are you with your relationship?__________

Please describe any relationship issues that are relevant to your counselling goals:

____

____

____

Please list any children/age____

____

____

ADDITIONAL INFORMATION:

Are you currently employed? □ No □ Yes

If yes, please describe your current employment situation:

____

____

____

What do you enjoy about your work? What do you not enjoy about your work?

____

____

____

____

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

If yes, please briefly describe your faith or belief:

____

____

What do you consider to be some of your strengths?

____

____

____

What do you consider to be some of your weakness?

____

____

____

What prompted you to pursue counselling at this particular point in time?

____

____

____

What would you like to accomplish out of your time in therapy?

____

____

____

Any other information that might be helpful for us to know?

____

____

____