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FOR OFFICE USE ONLY

Client #: _____

Diagnosis: _____

Insurance: _____

EAP: _____

Need Monthly Statement?
Y N

**CLIENT INTAKE
FORM**

Date: _____

The information requested in this form will be kept confidential.

GENERAL INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: ___/___/___ Age: ___ Gender: Male Female Other SIN # _____-_____-_____

Address: _____
(Street and Number)

(City) (Province) (Postal Code)

Employer: _____ Profession/Vocation: _____

Religious Denomination/Spiritual preference: _____

Home Phone: _____ May I leave a message? Yes No

Cell/Other Phone: _____ May I leave a message? Yes No

E-mail: _____ May I email you? Yes No

Emergency Contact: _____ Telephone: _____

Relationship to you: _____

Marital Status: Single Domestic Partnership Married Separated Divorced Widowed

Please list any children/age: _____

Referred by: _____

May we thank this person? Yes No

If so, please give contact information: _____

INSURANCE INFORMATION (if applicable):

Are you using insurance benefits? Y N

Are you: Primary Policyholder Dependent Relationship to Policyholder: _____

Insurance Company Name: _____

Street Address: _____ City: _____ Province: _____ Postal Code: _____

Insurance ID # _____ Group # _____

Policy Holder's Name: _____ Policy Holder's Birth Date: ___/___/___

Policyholder's SSN #: _____-_____-_____ Policyholder's Employer: _____

CLIENT INTAKE FORM, CONT.

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits? (Please Circle)

Poor Unsatisfactory Satisfactory Good Very good

How many times per week do you generally exercise? _____

Please list any difficulties you experience with your appetite or eating patterns:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No

Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? No Yes

Please list: _____

Have you ever been prescribed psychiatric medication? No Yes

Please list and provide dates: _____

Are you currently experiencing overwhelming 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? _____

Do you drink alcohol more than once a week? No Yes If yes, how often? _____

Do you currently use tobacco products? No Yes

How often do you engage in recreational drug use? Daily Weekly Monthly Infrequently Never

Are you currently in a romantic relationship? No Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? Bad 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 --- 10 Good

PLEASE CHECK ALL THAT APPLY & CIRCLE THE MAIN PROBLEM:

Difficulty with:	now	past	Difficulty with:	now	past	Difficulty with:	now	past
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following.

If yes, please indicate yourself and/or the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

History of:

yes / no

Yourself / Family Member Relationship:

Alcohol/Substance Abuse			
Anxiety			
Depression			
Domestic Violence			
Eating Disorders			
Obesity			
Obsessive Compulsive Behavior			
Schizophrenia			
Sexual Abuse			
Suicide Attempts			

COUNSELING CONCERNS:

What significant life changes or stressful events have you experienced recently?

Please describe the concerns that bring you to counseling at this time:

Please share what you hope to accomplish or gain through counseling:
