Intake Form

Name:____
Date of Birth:________________ Gender: M F Other:______________
Marital Status: Single ☐ Married ☐ Separated/Divorced ☐ Remarried ☐ Widowed ☐
Date married/divorced (if applicable):______________________________________

Contact Info:
Home Phone:__________________ Cell Phone:*___________________
What time of day is best?_____________________
Can we leave a voice message at this contact number?* Yes ☐ No ☐
Email:*____
May we email you?* Yes ☐ No ☐
Address:____
City:_____________________________Postal Code:_______________

In Case of Emergency:
Emergency contact:____________________________ Relationship:__________________
Phone: (home)________________(cell)_______________ (work)___________________

Payment Method: Etransfer ☐ Cheque ☐ Visa/MasterCard ☐ Cash ☐

Medical Info:
Primary Care Physician:______________________________Contact info:____________________
Medical conditions: ____
Previous medical conditions/surgeries: ____
Please list any medications you are currently taking, including natural supplements & vitamins:_____________
____
____

Services Required:
Individual Therapy ☐ Couples Therapy ☐ Family Therapy ☐ Child Therapy ☐ Other Group ☐
What issues bring you to counselling:____
____
____

Have you previously received any type of mental health services? Yes ☐ No ☐
When could you be available for an appointments?

	Morning	Afternoon	Evening
Monday	☐	☐	☐
Tuesday	☐	☐	☐
Wednesday	☐	☐	☐
Thursday	☐	☐	☐
Friday	☐	☐	☐
Saturday	☐	☐	☐

Treatment: Counselling is a collaborative relationship that empowers diverse individuals, families, and groups to find appropriate solutions to issues and to accomplish mental health, wellness, education, relationship, and career goals. It is not advise giving or a quick fix. It requires time and a commitment to go through the process together. The counselling relationship is not judgmental, but accepting and supporting for the client as they make decisions and changes to their lives in order to help reach their goals.

Treatment Termination: The counselling relationship will be terminated upon any of the following: 1) the client reaches their goals and no longer needs therapy, 2) the client-counsellor relationship is not conducive for the client's well-being, 3) there are issues of aggression or threats made against the therapist, 4) the client is referred to another therapist.

Referrals: If a client requires more care than I am qualified to give, they will be referred to a professional who is capable of providing that level of therapy or treatment.

Fees & Cancelation Policy: Fees for each session are to be paid prior to the beginning of the session. Notice of at least 24 hours is requested for cancellation unless for medical reasons.

Confidentiality: As Professional Therapist, I adhere to a strict standard of confidentiality and code of ethics. All of the information shared will not be disclosed to anyone without permission from you. Exceptions for disclosure: (1) When legal requirements demand material to be revealed for Federal or Provincial Court, (2) criminal code violations where physical and/or sexual abuse of children are involved, (3) whereby disclosure is required to prevent clear and imminent danger to the client or others. Most sessions are recorded by audio only and kept on a secure server, available only to myself and unless requested by court they are never released.

Minors: When working with minors, confidentiality to the parent/guardian will only be broken with permission from the minor, or in cases of abuse, self-harm, suicidal plans, or violent threats. However, I will give progress updates as needed, share the general direction of therapy, and encourage the client to have open communication with the parent/guardian.

I understand and agree to the content stated above:

Signed:_______________________________ Date_________________

PSYCHOLOGICAL ASSESSMENT:

Present Household:

Name (spouse/child)	Age	Relationship (bio/step/adopted)

Family of origin: (Household you grew up in - if same as above leave blank)

Parents: married ☐ single ☐ remarried ☐

Who was the primary care giver? ____________________

Sibling Name Gender Age Birth Order Describe/General characteristics Relationship (close/conflicted)

Sibling Name	Gender/Age	Birth Order	General Characteristics	Relationship (close/conflicted)

Please describe your mother's personality and your relationship to her growing up: ________________________
____
____

Please describe your father's personality and your relationship to him growing up: ________________________
____
____

What traits do you have from your mother?____
____

What traits do you have from your father? ____
____

What was your role in the family as you grew up? ____
____

How do/did your parents deal with conflict? ____
____

What was it like growing up in your family? ____
____
____
____

How did you relate to your siblings? ____
____
____

Psychiatric & medical history:

How have you been feeling? ____

How long have you been feeling this way? ____

Please list any non-pharmacological treatments you are currently in:__________________________________
____

Previous counselling? Y N If yes, at what age? _________ Reason for counselling: ___________________
____
Did you find it helpful? ____
Have you ever been treated for psychiatric problems? Yes ☐ No ☐ Hospitalized? Yes ☐ No ☐
Have you ever been on any psychiatric medications? Yes ☐ No ☐ If yes, please list:_____________________
____
Has anyone in your family ever been hospitalized for mental health related issues, attempted or committed suicide? ____

Have you ever experienced any of the following: If yes, how much does it interfere with your life?

Suicidal Thoughts	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
History of suicide attempts	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Self Harm	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Homicidal/violent thoughts	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
History of violent behaviour	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Paranoid thoughts	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Hallucinations	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Memory & cognitive problems	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Depression	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10
Anxiety	Yes ☐ No ☐	0—1—2—3—4—5—6—7—8—9—10

How nervous do you feel right now? 0—1—2—3—4—5—6—7—8—9—10
Any significant additional problems or stresses at this time? Yes ☐ No ☐ If yes explain: ____________
____

Traumas or significant losses:
Have you experienced or are you currently experiencing events that you consider to be emotionally, mentally, or physically traumatic? Yes ☐ No ☐ If yes, please explain:_______________________________________
____
____
(Please consider any from this list or others not listed: Abduction, bullying, chronic illness, cultural issues, criminal events, deaths, divorce/separation, emotional trauma, financial issues, hate crime, identity theft, internet fraud, isolation, loss of culture, loss of independence, medical/physical issues, sexual abuse, stalking, torture/war, witness of trauma, work related/job loss)

Please list any significant life changes or stressful events that you have experienced recently: _______________
____
____

Lifestyle Assessment:

Please rate your overall satisfaction with the following:

	☹1————☹2————😐3————🙂4—————5😁
Sleeping	1————— 2—————3—————4—————5
eating	1————— 2—————3—————4—————5
Family life	1————— 2—————3—————4—————5
sex life	1————— 2—————3—————4—————5
Work/occupation	1————— 2—————3—————4—————5
Other relationships	1————— 2—————3—————4—————5

Do you drink alcohol? Yes ☐ No ☐ If yes, how many per week? ___________

Do you smoke cigarettes? Yes ☐ No ☐ Do you use cannabis? Yes ☐ No ☐

Do you use any other recreational drugs? Yes ☐ No ☐

Do you have any addiction issues? (gambling, internet, shopping, pornography, gaming, alcohol, drugs)

Yes ☐ No ☐ If yes please list ____

Does anyone in your family have a history of substance abuse, addiction, physical or sexual abuse?

Yes ☐ No ☐ If yes please explain ____

____

Education & Career (if applicable):

Current level of Education: ____

Education goals: ____

Current employer: ____ date started: ______________________

Job description:____

Do you feel fulfilled at your work?____

Career goals: ____

Volunteer work:____

If you could pick a job, regardless of money or education, what would that job be? ________________________

____

Legal history:

Any outstanding legal matters?	Yes ☐ No ☐
Probation	Yes ☐ No ☐
Prison (past/current)	Yes ☐ No ☐
On going lawsuits?	Yes ☐ No ☐
Past legal matters?	Yes ☐ No ☐

Spiritual/religious beliefs: ____

Who do you turn to for support? (friends, church, family, professionals, neighbours, co-workers, virtual friends, children, partner, pets, other)____

____

Why did you decide that now is the time for therapy? ____

____

____

What are your short term goals or therapy? ____
____
What are your long term goals for therapy? ____
____

Client Attributes & Personality:

What are your strengths? ____
What are your weaknesses? ____
What are the things in life you view as the most important? ____
____
Hobbies/interests? ____
Has there been any change in your level of interest? Yes ☐ No ☐ If yes, please explain __________________
____

What do you do for fun and relaxation? ____
Who do spend most of your time with? ____

Sexual History:

What were your feelings surrounding your first date? ____
____
How old were you when you had your first sexual experience? _______ Was there intercourse? Yes ☐ No ☐
How many sexual partners have you had? ____
Please describe your significant other's personality and your relationship with them: ______________________
____
____
____

Cognitive Behaviour:

Are you a perfectionist? Yes ☐ No ☐
Do you have set routines, which if interrupted is upsetting? Yes ☐ No ☐
If yes, please explain ____
Do you check and recheck jobs you or others have already done? Yes ☐ No ☐
If yes, please explain ____
Do you have unwanted thoughts repeating in your mind? Yes ☐ No ☐
If yes, please explain ____
How well has your memory been lately? Good ☐ Poor ☐
How well has your concentration been lately? Good ☐ Poor ☐
How well do you make day-to-day decisions? Easily ☐ With Difficulty ☐
Do you ever see or hear things that others don't? Yes ☐ No ☐ I don't know ☐
Do you think people are always talking about you negatively? Yes ☐ No ☐
Do you think people are out to get you? Yes ☐ No ☐
How well do you feel you relate to others? 0—1—2—3—4—5—6—7—8—9—10

Is there anything we missed or you think I should know or would find helpful? _____________________________
____
____