CLIENT INTAKE FORM

Name:_____Address:_____

Phone: Home #: _____Work #:_____

Cell #: _____Email: _____

What time and day is best? _____
Okay to leave a phone message? Yes No Text message/Email? Yes No

Age	Date of Birth	Marital Status	Gender	Ethnicity/Race

Occupation: _____ Name of Employer /Workplace:_____

Emergency Contact: _____Relationship:_____
Phone: (Home)_____ (Cell)_____

Family Physician Name & Contact Info:_____

Intake Counsellor: _____ Referral Name: _____

Counselling Coverage (If Applicable):

Provider Name Band / Insurance Provider / Other	ID	Contact Information Phone / Address

Present Household:

Name Spouse / Child	Age Date of Birth	Relationship Married/Biological/Step	Location If Not in Home	Relationship General description

Confidentiality: As a Registered Professional Counsellor with the Canadian Professional Counsellors Association, I adhere to a strict standard of confidentiality. All the information between you and your intake counsellor or staff members will not be shared or disclosed to anyone without permission from you. I also adhere to a strict code of ethics. Exceptions (1) Federal or Provincial Court (2) criminal code violations where physical and/or sexual abuse of children are involved (3) whereby any person's life or health is in obvious danger.

I understand the above: Signature:_____Date:_____
Witness:_____Date:_____

PSYCHOSOCIAL ASSESSMENT

PRESENTING PROBLEM:

What brought you here today?

_____

_____

_____

_____

FAMILY HISTORY:

Present Household:

Name Spouse / Child	Age Date of Birth	Relationship Married/Biological/Step	Family Member General Characteristics	Relationship General description

Household you grew up in:

Sibling Name	Gender M/ F	Age	Birth Order oldest/youngest	Family Type single parent/ blended/traditional	Describe your Sibling General characteristics	Relationship Conflicted/Close

Tell me about your **mother**, step mother and/or other significant female care providers? What were their personalities like, how did they treat you, and what has been your relationship with them over the years including now?

Did mother have any complications during pregnancy &/or delivery?
____Yes _____No
Did mother drink, smoke or use illicit drugs during pregnancy?
____Yes _____No

Tell me about your **father**, step father and/or other significant male care providers? What were their personalities like, how did they treat you, and what has been your relationship with them over the years including now?

Tell me about your earliest childhood memory. Any significant family events during your growing up years?

How did your family handle conflict? How did your family communicate with each other?

What do you like & dislike about your family?

MEDICAL HISTORY

Tell me about any medical problems you have –chronic illnesses, traumatic injuries, head injuries, major surgeries, chronic pain? Includes dates, hospitalization information, disabilities.

LIFE STYLE

Physical Health (1 is poor, 10 is excellent): Rating_____

Sleep (any concerns): Hours/Night_____

Exercise: Form(s):
How Often: Regularly _____ Sometimes _____ Rarely _____

Sex Life (how satisfied are you): Rating_____

Medication(s):

Prescription Type	Diagnosis	How Often	How Long

Alcohol Intake:

Amount (per use)	Frequency (per day/week)	How Long (months, years)

Drugs:

Type	How Much	How Often	How Long	Treatment

Have you ever had a period of heavy alcohol or drug use?Please describe.

Has any member of your family had a period of heavy alcohol or drug abuse, past or present? Please describe.

Has or does drug and alcohol use interfere with or negatively affect your life?

Have you experienced any of the following symptoms of withdrawal?
Tremors Nausea Vomiting Sweats Seizures Hallucinations Others

ADDICTIONS - *Please check all that apply*

Alcohol	_____	Drug (illegal and/or prescription)	_____
Food	_____	Sex	_____
Gambling	_____	Shopping (includes online)	_____
Smoking	_____	Internet	_____

Age of Onset	How Often	Last Use	Treatment	Consequences of Abuse

EMOTIONAL/MENTAL HEALTH

How would you describe yourself emotionally?

Have you had any thoughts of hurting yourself or another?
Any current suicidal thoughts, &/or intent to end your life? Yes _____No_____
Do you presently or have you in the past had any:

Risk Factor	Yes	No	Comments
Suicidal Thoughts			
History of Suicide Attempts			
Homicidal / Violent Thoughts			
History of Violent Behaviour			
Paranoid Thoughts			
Hallucinations			

SUICIDE RISK ASSESSMENT:

Harm to **Self**: None_____ Low_____Medium _____ High _____
Harm to **Others**: None_____ Low_____Medium _____ High _____

Hospitalization/treatment for psychiatric problems? _____

Any memory & cognitive problems? _____

What significant problems or stresses are you facing at the present time?

SPIRITUAL/RELIGIOUS BELIEFS

Is there any specific belief system that you follow that I need to be aware of?

Did religion/spiritual practice play a part in your upbringing?

RELATIONSHIP HISTORY

List any significant relationships in your life (for example marriage, common-law union, long term dating, divorced) starting with the most recent or current:

Status: (Dating, Married, Divorced)	Duration:	Age (of onset):	Crises / Abuse : (verb/sex/phys)	Other Relevant Info :

Sexual Orientation:

TRAUMAS or SIGNIFICANT LOSSES

Have you experienced any traumas you think we should address?

Checklist of Examples:

Abduction	Bullying	Chronic Illness
Cultural	Criminal	Deaths
Divorce / Separation	Emotional	Financial
Hate crime	Identity theft	Internet Fraud
Isolation	Loss of Culture	Loss of Independence
Medical / Physical	Sexual Abuse	Stalking
Torture / War	Witness of Trauma	Work Related/Job Loss

EDUCATION

Current Level of Education: _____
Educational Goals: _____

CAREER

Current employment/job description? _____
Employment History? _____
Level of job satisfaction) 1-5) _____Why? _____
Gaps in Employment History? _____
Reasons for Leaving? _____
Any volunteer work? _____

LEGAL HISTORY

Describe any legal (criminal) problems you have ever had. Describe any violent behaviour you have ever exhibited.

Any outstanding legal matters? _____

_____Probation? _____In jail (past/current)

On going lawsuit(s)? _____

Past legal matters? _____

SUPPORT SYSTEMS

Have you attended counselling before? ____Yes _____No

If yes: When? Age? Reason(s)?

What was helpful / not helpful?

Anything missed / not addressed?

Who do you turn to for support? Reason you would choose these supports?

Friends _____ Church _____ Professionals _____ Neighbours _____ Co-workers _____

Virtual Friends _____ Children _____ Partner _____ Pets _____ Family_____

CLIENT ATTRIBUTES

Tell me about your strengths, hobbies, interests. What do you like to do for fun and relaxation?

If you were granted 3 wishes what would they be & how might they change your life?

TREATMENT GOALS

What would you like to achieve in our work?

1.
2.
3.

Is there anything I did not ask that you thought I would, or anything else you think would be helpful?

RECOMMENDATIONS