Client Intake Form for Counselling Services:

Personal Information

Name:____ Date: ________________________ Parent/Legal Guardian (if under 18): ____

Address: ____ Home Phone: _______________________________ May we leave a message? □ Yes □ No Cell/Other Phone: ____________________________ May we leave a message? □ Yes □ No Email: _____________________________________ May we leave a message? □ Yes □ No *Please note: Email correspondence is not considered to be a confidential medium of communication.
DOB: ______________________________ Age: _______ Gender Identity: _____________

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Referred By (if any): ____

History

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

2. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good 3. How many times per week do you generally exercise? □ Yes □ No

4.Do you have difficulties with your appetite or any eating problems? □ Yes □ No

5. Are you currently experiencing overwhelming sadness, grief or depression?□ No □Yes

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □No□Yes

7. Are you currently experiencing any chronic pain? □ No □ Yes

8. Do you drink alcohol more than once a week? □ No □ Yes

9. Do you engage in recreational drug use? □ No □ Yes

10. Is there a family history of mental health concerns and/or diagnosis? □ No □ Yes

11. Have you previously received any type of mental health services? □ No □ Yes

12.Are you currently taking any prescription medication? □ Yes □ No

13. What would you like to achieve through counselling? Do you have any goals or particular reasons you would like to focus on?

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14. Is there anything else you would like me to know?

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