Client Intake Form

*Please fill out this form and bring it to your first session. By taking the time to fill out this questionnaire it will enable me to quickly understand your history and the reasons that have brought you to therapy. It will also help you clarify your personal goals. The information provided is confidential.

Name:_____

Name of Parent/Guardian (if you are under the age of 18):

_____

Address:_____

City:_____ Postal Code: _____

RES#: _____ May I leave a message? Yes/No

Work#:_____ May I leave a message? Yes/No

Mobile #:_____ May I leave a message? Yes/No

Email Address (Email correspondence is not considered a confidential method of communication):

_____

May I email you? Yes/No

Who referred you to me? _____

Occupation: _____

Are you currently employed: Yes/No

Age: _____ Birthdate: _____

Marital Status (please circle)

Never Married Cohabiting Married Separated Divorced Widowed

List the name(s) of children with their age and gender:

_____

_____

Emergency Contact Name and Number:

_____

General Health and Mental Health Information

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

Poor Unsatisfactory Satisfactory Good Very Good

Name of your physician?_____

When was your last check up?_____

Please list any specific health problems you are currently experiencing:

_____

_____

_____

2. Did you experience any significant illnesses during childhood or adolescence?

_____

_____

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

Poor Unsatisfactory Satisfactory Good Very Good

4. How many times per week do you generally exercise? _____

What types of exercise do you participate in?

_____

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

6. Are you currently experiencing overwhelming sadness, grief or depression? Yes/No
If yes, for approximately for how long:_____

7. Are you currently experiencing anxiety? Yes/No
If yes, for approximately for how long:_____

8. Have you previously received any type of mental health services (psychotherapy, psychiatric services etc)? Yes/No

If yes, when and for how long? Names of previous therapist:
_____
_____
_____

9. Are you currently taking any prescription medication? Yes/No

Have you ever been prescribed psychiatric medications? Yes/No

Please list and provide dates when prescribed:
_____
_____
_____

10. Indicate if there is a family history of any of the following. If yes, please indicate the family member's relationship to you:

Alcohol/Substance Abuse: Yes/No _____
Anxiety: Yes/No _____
Depression: Yes/No_____
Eating Disorders: Yes/No_____
Schizophrenia:_____
Suicide Attempts: Yes/No _____
Obsessive Compulsive Behaviour: Yes/No_____
Domestic Violence: Yes/No _____

Circle any of the following that may apply to you:

Headaches Inferiority feelings Shy with people Dizziness Feel Tense
Can't make friends Fainting spells Feeling panicky Afraid of people
No appetite Binge eating Fears and phobias Poor home conditions
Obsessions Unable to enjoy yourself Stomach trouble Depressed
Always worried Suicidal feelings Often fatigued Need for tranquilizers
Alcoholism Overambitious Unable to relax Drug Use
Financial Problems Infidelity Insomnia Gambling Recurrent dreams
Job problems Nightmares Sexual problems Hallucinations

Do you drink alcohol? If yes, how much?

_____

Do you use recreational drugs? If so, what kind and how often?

_____

_____

Risk Assessment

Any risk factors present? Yes/No

If yes, specify current risk factors

Potential for violence : Yes/No

Hostile /Abusive Behaviour : Yes/No

Major Depression: Yes/No

Suicidal Ideation/Intent/Plan: Yes/No

Past Risk Factors

Suicide Attempts: Yes/No

Violent Behaviour : Yes/No

Inpatient Hospitalization: Yes/No

Hostile/Abusive Behaviour : Yes/No

Major Depression : Yes/No

Suicidal Ideation/Intent/Plan: Yes/No

Family Of Origin

Father's Name:_____ Age : _____

Occupation:_____

Health (If deceased: circumstance and how loss affected you):

_____

_____

_____

Describe your father's personality and the nature of your relationship with him past and present:

_____
_____
_____
_____

Mother's name:_____ Age:_____

Occupation:_____

Health (if deceased: circumstance and how the loss affected you):

_____
_____
_____
_____

Describe your mother's personality and the nature of your relationship with her past and present:

_____
_____
_____
_____

Siblings

Name:_____ Age:_____

Occupation:_____

Name:_____Age :_____

Occupation:_____

Name: _____ Age:_____

Occupation:_____

Name :_____ Age :_____

Occupation:_____

Name:_____Age :_____

Occupation:_____

Describe your relationship with your siblings (past and present):

_____
_____
_____
_____

Were there other adults involved in your upbringing? Yes/No

If yes, whom:_____

Describe the atmosphere in your childhood home:

_____
_____
_____
_____

Romantic Relationships

Are you currently in a relationship? Yes/No

If yes, for how long:_____

Do you live with your partner? Yes/No

Describe your partner's personality:

_____
_____
_____

On a scale of 1-10, how would you rate your relationship? _____

Give details on any previous marriages or long-term relationships?

_____
_____
_____

Self Description

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

_____
_____
_____

Do you enjoy your work? Is there anything stressful about your current work?

_____
_____
_____

Do you have any spiritual or cultural affiliations? Yes/No
If yes, please describe:

_____
_____
_____

What do you consider to be some of your strengths?

_____
_____
_____

What do you consider to be some of your weaknesses?

_____
_____
_____

What do you do for pleasure or as a way to unwind?

_____
_____
_____

What brings you to therapy and what would you like to accomplish?

_____
_____
_____
_____
_____

Thank you for taking the time to complete this extensive questionnaire. It helps me to help you!

Signature:_____ Date:_____