CLIENT INTAKE FORM

Please fill in the information below and email back to info@seekcounselling.ca. All information provided on this form is protected as confidential information.

PERSONAL INFORMATION

Please fill in all applicable areas or mark n/a if not applicable.

First Name: ________________________________ Last Name: _________________________________

Preferred Name: _______________________________ Pronouns: _______________________________

Parent/Legal Guardian: ____

Home Phone: __________________________ May we leave a message? Yes _____ No _____

Cell/Work/Other Phone: __________________________ May we leave a message? Yes ____ No ____

Email: ____ Please note, email correspondence is not considered to be a confidential medium of communication.

Date of Birth: _______________________________ Age: ________

Relationship status:

Single: ______ New Relationship: ______ Domestic Partnership: ______ Married: ______

Separated: ______ Divorced: ______ Widowed: ______ It's complicated: ______

How did you find us? ____

HISTORY

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

Yes: ______ No: ______ If yes, are you comfortable naming your last therapist or practitioner:

____

What did you find useful about your past experiences with therapy? ____________________________

____

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____

CLIENT INTAKE FORM

Was there anything that you didn't like about your past experiences with therapy? _______________

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Are you currently taking any prescription medications? Yes: ______ No: ______

If yes, please list: ____

____

Have you ever been prescribed psychiatric medication? Yes: ______ No: ______

If yes, please list medications and provide dates: ____

____

____

____

GENERAL AND MENTAL HEALTH INFORMATION

How would you describe your current physical health? (Please check just one)

Poor: ______ Unsatisfactory: ______ Satisfactory: ______ Good: ______ Very Good: ______

Please list any specific health problems you may be currently experiencing:

____

____

____

____

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

Poor: ______ Unsatisfactory: ______ Satisfactory: ______ Good: ______ Very Good: ______

Please list any specific sleep problems you may be currently experiencing:

____

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How many times per week do you exercise? ______________________________________

What types of exercise do you usually do? ______________________________________

____

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

____

____

____

____

Are you currently experiencing overwhelming sadness, grief, or depression? Yes: ____ No: _____

If yes, when did you begin experiencing this? ____________________________________

Are you currently experiencing any chronic pain? Yes: ______ No: ______

If yes, please describe: ____

____

____

Do you drink alcohol more than once a week? Yes: ______ No: ______

How often do you engage in recreational drug use?

Daily: ______ Weekly: ______ Monthly: ______ Infrequently: ______ Never: ______

Are you currently in a romantic relationship? Yes: ______ No: ______ Sort of: ______

If yes or sort of, for how long: ____

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On a scale of 1-10 (with 1 being poor and 10 being exceptional, how would you rate your relationship?): ______________

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

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FAMILY MENTAL HEALTH HISTORY

In the section below, please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided. You don't have to write their name, rather, their relationship (father, sister, mother, grandparent etc.)

ISSUE:	CHECK YES	CHECK NO	LIST FAMILY MEMBER
Alcohol or Substance Abuse	Yes: ______	No: ______	______________________________ ______________________________ ______________________________ ______________________________
Anxiety	Yes: ______	No: ______	______________________________ ______________________________ ______________________________ ______________________________
Depression	Yes: ______	No: ______	______________________________ ______________________________ ______________________________

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Domestic Violence	Yes: ______	No: ______	
Eating Disorders	Yes: ______	No: ______	
Obsessive Compulsive Behaviour	Yes: ______	No: ______	
Schizophrenia	Yes: ______	No: ______	
Bipolar Disorder	Yes: ______	No: ______	
Personality Disorders	Yes: ______	No: ______	

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			____________________ ____________________ ____________________ ____________________
Suicide Attempts	Yes: ______	No: ______	____________________ ____________________ ____________________ ____________________

ADDITIONAL INFORMATION

Are you currently employed? Yes: ______ No: ______

If yes, what is your currently employment situation: ____

____

____

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

____

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____

Do you consider yourself to be spiritual or religious? Yes: _____ No: ______

If yes, please describe your faith or belief: ____

____

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CLIENT INTAKE FORM

What do you consider to be some of your strengths? ______________________________________

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What do you consider to be some of your weaknesses? ____________________________________

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What would you like to accomplish during our time in therapy together? ______________________

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Bonus question: Looking back on your life, what was your favourite day or experience that you can recall?

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