Tim Rieck Psychotherapy

CLIENT INTAKE FORM

Please take a moment to complete this Client Intake Form with as much information as possible *prior to your first session.*

PART 1: PERSONAL INFORMATION

First Name: _____ Last Name: _____ Date of Birth: _____

Address: _____ _____ _____
Address City Postal Code

Home Phone: (____) ____-_____ *May I leave a message at this number?* ☐ YES ☐ NO

Cell Phone: (____) ____-_____ *May I leave a message at this number?* ☐ YES ☐ NO

Work Phone: (____) ____-_____ *May I leave a message at this number?* ☐ YES ☐ NO

Email Address: _____

Emergency Contact Name: _____ Phone Number: (____) ____-_____

Physician's Name: _____ Phone Number: (____) ____-_____

PART 2: MARITAL STATUS AND HOUSEHOLD INFORMATION

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐ Common Law ☐ Partner

Partner's Name: _____ Partner's Date of Birth: _____

Children or Dependants:

First Name	Last Name	Relationship	Year of Birth

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PART 3: PLEASE COMPLETE THE FOLLOWING QUESTIONS

What are the concerns that you wish to discuss in therapy?

_____

_____

_____

How long have you had these concerns? _____

How are these concerns interfering with your life right now? _____

_____

What have you tried that has helped at times? _____

_____

Are things getting better or worse now? _____

Would you like anyone to join you in therapy? (Family or Friends) _____

Have you attended counselling/therapy before? _____ If so, when? _____

What did you find most helpful? _____

Have you ever had the support or needed access to family child services? ____

If so, when? _____

Was it helpful? _____

Do you think that you or anyone in your family is at risk for any reason? Who? Please explain:

_____

_____

What do you wish to take away from therapy? What is your ideal outcome? _____

_____

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For the following questions, please scale your level of concern on a scale of 0-10 (with 0 being no concern at all and 10 being highly concerned)

Are there concerns about any medical problems or the use of medication? Level of Concern: __
Please explain: _____

_____

Are there concerns about alcohol or drug abuse? Level of concern: __
Do the substances affect your life or your relationships? If so, how? _____

_____

Are there concerns about abuse or violence in your life? Against you or from you?
Level of concern: __ Please explain: _____

_____

Is there any past history or present concern about self-harm? Level of concern: __

_____

_____

Is there any past history or present concern about suicide? Level of concern: __
What helps you to keep choosing life? _____

_____

Do you have any general medical conditions that you have not listed yet? (i.e. thyroid disease, diabetes, etc.) _____

Is there anything else that you would want your therapist to know about yourself at this time?

_____

_____