

**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 Dependents:

First Name	Last Name	Relationship	Year of Birth

**PART 3: PLEASE COMPLETE THE FOLLOWING QUESTIONS**

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

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How long have you had these concerns? \_\_\_\_\_

How are these concerns interfering with your life right now? \_\_\_\_\_

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What have you tried that has helped at times? \_\_\_\_\_

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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:

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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?