CLIENT INTAKE FORM

The information provided on this form is protected as confidential information.

Name: _____ Preferred Name: _____

Date of Birth: _____ Gender Identity: _____ Pronouns: _____

Best Phone Number to contact you: _____ Message okay? ☐ Yes ☐ No

Email: _____ Physician: _____

Address: _____

Parent or Legal Guardian(s) if under age 18: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Background

Languages spoken: _____

Culture: _____ Education: _____

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

Are you having thoughts of hurting yourself or others? ☐ Yes ☐ No Are you currently in crisis? ☐ Yes ☐ No

If you are CURRENTLY in distress, please call the Calgary Distress Centre at 403-266-4357 (24/7)

Others Living in the Home:

NAME	DOB	M/F	RELATIONSHIP

PERSONAL HISTORY

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

☐ No ☐ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? ☐ No ☐ Yes, please list medications:

_____

_____

_____

_____

When was the date of your last physical exam? _____

How would you rate your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health problems you are currently experiencing:

_____

_____

_____

_____

How would you rate your current sleeping habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep problems you are currently experiencing:

_____

_____

_____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in?

_____

_____

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

_____

_____

_____

_____

Average Screen Time per day: _____

Self-Care practices: _____

_____

Who is in your support network? _____

Are you experiencing overwhelming sadness, grief, or depression? ☐ No ☐ Yes, how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ No

☐ Yes, when did you begin to experience this? _____

Are you currently experiencing chronic pain? ☐ No

☐ Yes, please describe: _____

_____

Are you in a romantic relationship? ☐ No ☐ Yes, For how long? _____

How would you rate your romantic relationship?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Current significant relationship stressors:

_____

_____

_____

_____

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

_____

_____

_____

Are you currently employed? ☐ No ☐ Yes **Do you enjoy your work?** ☐ No ☐ Yes

Is there anything stressful about your current work?

_____

_____

_____

Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes, describe your faith or belief:

_____

_____

_____

What do you consider to be some of your strengths?

_____

_____

_____

What is your primary reason for seeking counselling at this time?

_____

_____

_____

_____

What would you like to accomplish out of your time in therapy/what are your therapy goals?

_____

_____

_____

_____