

CONFIDENTIAL Counselling & Psychotherapy Intake (2018) Heather Macmillan, M Ed , RCT-C, CCC

Name(s): _____ AGE: _____

Date of Birth (Month/day/year): _____

Address: _____

CLIENT #: _____
INTAKE DATE: _____

Preferred Communication: email tel. text. Email address: _____

Telephone: (_____) _____ - _____ May I leave messages for you? Yes No

Emergency Contact: _____ Telephone _____
Relationship to Client: _____

Current Family Situation

Single Partner Married Divorced Separated Blended Widowed Foster/Adoptive family
 Children _____ (names/ages)

Occupation/Employed/Unemployed: _____

Reason for seeking support at this time? _____

What changes would you like to see happen as a result of working together?

What contributes to the problem? What makes it worse?

In the past, what have you done to try to cope with the problem?

Have you consulted a therapist before? Yes No Date(s) _____

How did you find out about my services? _____

Personal History ~ Please check any of the following that are concerns for you:

<input type="checkbox"/> Alcohol use	<input type="checkbox"/> Internet use/Virtual reality
<input type="checkbox"/> Anger/Irritability	<input type="checkbox"/> Suicidal thoughts/attempts
<input type="checkbox"/> Drug use	<input type="checkbox"/> Finances/Debt
<input type="checkbox"/> Anxiety/Panic	<input type="checkbox"/> Sleep difficulties
<input type="checkbox"/> Gambling	<input type="checkbox"/> Eating/Body image
<input type="checkbox"/> Depression/Low mood	<input type="checkbox"/> Gender identification
<input type="checkbox"/> Work difficulties	<input type="checkbox"/> Family conflict
<input type="checkbox"/> Stress	<input type="checkbox"/> Loss/Grief
<input type="checkbox"/> Self-esteem	<input type="checkbox"/> Sexual difficulties
<input type="checkbox"/> Historical assault or abuse (verbal/sexual/ physical)	<input type="checkbox"/> Chronic Illness or pain
<input type="checkbox"/> Motor vehicle collision/Accidents (recent/past)	<input type="checkbox"/> Recent assault or abuse (sexual/physical)
<input type="checkbox"/> Relationship difficulties	<input type="checkbox"/> Other (please specify)

Are you now or have you ever been exposed to:

Physical Violence	<input type="checkbox"/> Current <input type="checkbox"/> Past	Sexual Abuse	<input type="checkbox"/> Current <input type="checkbox"/> Past
Emotional/Verbal Abuse	<input type="checkbox"/> Current <input type="checkbox"/> Past	Workplace Harassment	<input type="checkbox"/> Current <input type="checkbox"/> Past
Family Addictions	<input type="checkbox"/> Current <input type="checkbox"/> Past	Motor Vehicle Collision	<input type="checkbox"/> Current <input type="checkbox"/> Past
Surgical trauma	<input type="checkbox"/> Current <input type="checkbox"/> Past	Accident/injury	<input type="checkbox"/> Current <input type="checkbox"/> Past

Other frightening or overwhelming experiences (simply name, no description necessary)

Do you have a family doctor? Yes No (name/location): _____

Other health professionals actively involved in your healthcare? Yes No

Do you smoke? Yes No If so, what kind, how much per day/week? _____

Please list any medical diagnoses or health conditions:

Please list medications/supplements/other substances you are currently taking and for what reason:

Anything else you'd like to share that would better help me to understand you? _____
