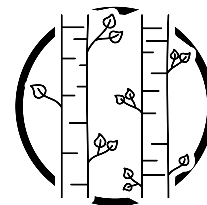

CLIENT INTAKE FORM

Please fill out your demographic and contact information.
For the questionnaire sections, please fill out as much or as a little as you feel comfortable.
The information you provide will be helpful to prepare for your session.

DEMOGRAPHIC INFORMATION

First Name:

Last Name:

Date of Birth:

Name you would like to be called (if different from above):

Place of Birth:

Primary Language:

Gender:
(current gender, which may be different than what is indicated your insurance policies)

Relationship Status: ☐ single ☐ in partnership ☐ married ☐ divorced ☐ widowed ☐ other

If in partnership, partner's name & date of birth:

Child/children's name(s) and date(s) of birth:

HOME ADDRESS

Street:

City:

Province:

Postal Code:

MAILING ADDRESS (if different than home address)

Street:

City:

Province:

Postal Code:

PERSONAL CONTACT INFO

Home: May I leave a message? ☐ Yes ☐ No

Mobile: May I leave a message? ☐ Yes ☐ No

Work: May I leave a message? ☐ Yes ☐ No

E-mail Address (personal):

IN CASE OF EMERGENCY

Contact Name: Relationship to you:

Phone: Mobile:

E-mail address:

Does your Emergency Contact know that I am your therapist? ☐ Yes ☐ No

WORK INFORMATION

Occupation:

Employer's name:

CLIENT QUESTIONNAIRE

1. Please describe in your own words the primary issue(s) for which you are seeking therapy:

2. How long have you been experiencing the current issue? When did it occur?

3. Please describe your expectations of counselling. Let me know if you have some thoughts on how we can work best together, in terms of what would be helpful and what you may have already learned along the way. (In other words, how will things be different when counselling is successfully completed?)

1. Please check which BEHAVIOURS recently apply to you:

☐ Frequent Crying	☐ Drink too much	☐ Sleep Problems	☐ Other: ____________
☐ Hyperactive Behavior	☐ Withdrawing	☐ Irresponsibility	☐ Other: ____________
☐ Lack of Assertiveness	☐ Arguing/ Irritability	☐ Self Neglect	☐ Other: ____________
☐ Lack of Energy	☐ Drug use	☐ Indecisiveness	
☐ Temper Outbursts	☐ Eating Problems	☐ Working too much	

2. Please check which FEELINGS recently apply to you:

☐ Restless	☐ Fearful	☐ Depressed	☐ Sad	☐ Annoyed
☐ Guilty	☐ Bored	☐ Unhappy	☐ Irritable	☐ Jealous
☐ Energetic	☐ Unreal	☐ Unattractive	☐ Relaxed	☐ Unmotivated
☐ Content	☐ Panicky	☐ Worthless	☐ Empty	☐ Other: ____________
☐ Confused	☐ Lonely	☐ Hopeful	☐ Happy	☐ Other: ____________
☐ Moody	☐ Stressed	☐ Angry	☐ Ashamed	☐ Other: ____________
☐ Mistrustful	☐ Like a failure	☐ Optimistic	☐ Excited	
☐ Nervous	☐ Helpless	☐ Inferior	☐ Hopeless	

3. Please check which PHYSICAL symptoms recently apply to you:

☐ Headaches	☐ Back Pain	☐ Chest Pains	☐ Loss of Sex Drive
☐ Dizziness	☐ Tiredness	☐ Fainting Spells	☐ Excessive Sweating
☐ Twitches/ spasms	☐ Memory Problems	☐ Black Outs	☐ Appetite Change
☐ Stomachaches	☐ Dry Mouth	☐ Overly Tense	☐ Other: ____________
☐ Racing Thoughts	☐ Tremors/ shakiness	☐ Cannot Concentrate	☐ Other: ____________
☐ Numbness/ tingling	☐ Rapid Heartbeat	☐ Dizziness	☐ Other: ____________

4. What are your major strengths, or what do you like about yourself?

5. What major transitions have you had in the past two years? (i.e. – entering or approaching a new decade of life, a new relationship, a new job, a new role, a new residence, changes in children's ages/stages of life, separation, divorce, death of a loved one, birth of a child, marriage, etc.)

6. Who are the key people in your life and what do they provide for you?

7. On a scale of 1 – 10 (10 = HIGH), rate your current level of stress:
What would you like it to be?

8. What are your primary stressors?

9. On a scale of 1 – 10, (10 = HIGH), rate the quality of your life:
today: What would you like it to be?

Referral:

How did you hear about *Birch Cove Counselling*? ______________________________________

PHYSICAL & MENTAL HEALTH

This information will not be shared with your healthcare providers without your informed, written consent in advance.

1. Do you currently have a primary physician? ☐ Yes ☐ No
   Physician's Name: Phone:

2. Are you currently being seen by a psychiatrist? ☐ Yes ☐ No
   Psychiatrist's Name: Phone:

3. Are you currently being seen by another counselor/therapist? ☐ Yes ☐ No
   Counselor's Name: Phone:

4. Rate your current level of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

5. Are there any serious health problems/disabilities/accidents (current, recent, or past) that I should know about or discuss? ☐ Yes ☐ No

6. What medications are you CURRENTLY prescribed for your physical and mental health?

Medication	Prescribed for?	Date Begun	Taken as Prescribed?	Prescribing Physician
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

7. Please list any medication you were prescribed in the PAST.

Medication	Prescribed for?	Date Begun	Taken as Prescribed?	Prescribing Physician
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

8. Have you received counselling in the past? Yes No

9. What type of counselling?
   ☐ Individual ☐ Marital ☐ Family ☐ Alcohol abuse ☐ Substance Abuse
   ☐ Other (please specify):

   ☐ Inpatient When:
   ☐ Outpatient Was it helpful? ☐ Yes ☐ No If no, explain:

Name of Provider/Facility: Issue Addressed:

Additional info.:

SAFETY RISK INFORMATION

1. Have you or any close family members ever been suicidal or experienced a mental illness? ☐ Yes ☐ No
2. Have you had any recent thoughts about harming or killing yourself? ☐ Yes ☐ No
3. Have you ever attempted suicide? ☐ Yes ☐ No If yes, when? ___________
4. Have you had any recent thoughts about, or have recently harmed anyone else? ☐ Yes ☐ No

FAMILY OF ORIGIN/DEVELOPMENTAL INFORMATION

1. Who primarily raised you?
2. Who raised you in your first three years of life?
3. Did your parents experience separation/divorce? ☐ Yes ☐ No
   If yes, how old were you? _________
4. How many brothers and sisters do you have?

Brothers:	Step-brothers:	Half-brothers:
Sisters:	Step-sisters:	Half-sisters:

5. What was your order in birth? ☐ Only child ☐ Youngest ☐ Middle ☐ Oldest

SOCIAL SUPPORT / SELF-CARE INFORMATION

1. How would you describe your current social interaction/support?
2. How did you meet your friends?
3. What activities do you enjoy?
   Alone: With friends/family:
4. How often do you exercise?
5. What type of exercise, if any, do you enjoy or engage in?
6. How would you describe your eating habits?