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CLIENT INTAKE FORM

Please provide the following information for my records. Leave blank any question you would rather not answer, or would prefer to discuss in session. Information you provide here is held to the same standards of confidentiality as our therapy. If you need more space, please use the back of this form.

DEMOGRAPHIC INFORMATION

Full Name (*first, middle, last*)	
Date of Birth (*dd/mmm/yyyy*)	
Home Address	Street# and Name: City: Province: Postal Code:
E-mail	
Home Phone	
Cell Phone	
Pronoun Preference *(circle)*	she/her he/him they/them
Relationship status (*circle)*	single married separated divorced other (*please describe*) Length of current relationship?

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counselling or psychotherapy elsewhere? *(circle)*	**Yes**	**No**
Have you had previous psychotherapy? *(circle)*	**Yes**	**No**
If yes, provide any details you are comfortable giving at this time.		

Treatment History questions continued on the next page…

TREATMENT HISTORY CONTINUED…

Are you currently taking prescribed psychiatric medication (antidepressants or others)? *(circle)*	**Yes**	**No**
If yes, please list and by whom they were prescribed.		

HEALTH AND SOCIAL INFORMATION

Do you have a primary physician? *(circle)*	**Yes**	**No**
If yes, who is it?		
Are you currently seeing more than one medical health specialist? *(circle)*	**Yes**	**No**
If yes, please list?		
When was your last physical?		
Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.:)		
Are you currently on medication to manage a physical health concern? *(circle)*	**Yes**	**No**
If yes, please list?		
Are you having any problems with your sleep habits? *(circle)*	**Yes**	**No**
If yes, circle all that apply? **Sleeping too little** **Sleeping too much** **Poor quality of sleep** **Disturbing dreams** Other *(please describe)*:		

Health and social information continued on the next page…

How many times per week do you engage in physical activity? *(enter number)*		
Estimate average length of time of the physical activity? *(enter number)*		
List types of physical activity:		
Are you having any difficulty with appetite or eating habits? *(circle)*	**Yes**	**No**
Have you experienced any significant weight **GAIN** in the last two months? (*circle*)	**Yes**	**No**
Have you experienced any significant weight **LOSS** in the last two months? (*circle*)	**Yes**	**No**
If yes, circle all that apply? **Eating less** **Eating more** **Binge eating** **Food Restricting** **Purging** If purging, describe method used (*laxatives, vomiting, other*): Other eating disturbances *(please describe)*:		
Do you use alcohol regularly? (*circle*)	**Yes**	**No**
How many days per week do you drink alcohol?		
How many drinks do you drink each time you use alcohol?		
In a typical month, how often do you have 4 or more drinks in a 24 hour period?		
Do you smoke cigarettes or use other tobacco products?	**Yes**	**No**
How many cigarettes do you smoke on average per day?		
How often do you engage in recreational drug use? (*circle*) Daily weekly monthly rarely never		
Which recreational drugs do you use?		
Which recreational drugs have you tried in the past?		

Health and social information continued on the next page…

Have you had suicidal thoughts in the last two months? (*circle*)			
frequently	sometimes	rarely	never

Have you had suicidal thoughts in the past? (*circle*)			
frequently	sometimes	rarely	never

In the last year, have you experienced any significant life changes or stressors?	**Yes**	**No**
If yes, please explain:		

Have you ever experienced any of the following?

Extreme depressed mood (*circle*)	**Yes**	**No**
Dramatic mood swings (*circle*)	**Yes**	**No**
Rapid speech (*circle*)	**Yes**	**No**
Extreme anxiety (*circle*)	**Yes**	**No**
Panic attacks (*circle*)	**Yes**	**No**
Phobias (*circle*)	**Yes**	**No**
Sleep disturbances (*circle*)	**Yes**	**No**
Hallucinations (*circle*)	**Yes**	**No**
Unexplained losses of time (*circle*)	**Yes**	**No**
Unexplained memory lapses (*circle*)	**Yes**	**No**
Alcohol/substance abuse (*circle*)	**Yes**	**No**
Frequent body complaints (*circle*)	**Yes**	**No**
Eating disorder (*circle*)	**Yes**	**No**
Body image problems (*circle*)	**Yes**	**No**

Health and social information continued on the next page…

Question		
Repetitive thoughts (e.g. obsessions) (*circle*)	**Yes**	**No**
Repetitive behaviors (e.g. frequent checking, hand washing) (*circle*)	**Yes**	**No**
Homicidal thoughts (*circle*)	**Yes**	**No**
Suicidal attempts (*circle*)	**Yes**	**No**
If yes, provide details:		

OCCUPATIONAL INFORMATION

Question		
Are you currently employed? (*circle*)	**Yes**	**No**
If yes, are you happy with your current position? (*circle*)	**Yes**	**No**
If yes, provide details, position, industry, etc:		
Please describe any work stressors:		

RELIGIOUS/SPIRITUAL INFORMATION

Question		
Do you consider yourself to be religious? (*circle*)	**Yes**	**No**
If no, do you consider yourself to be spiritual? (*circle*)	**Yes**	**No**
If yes, what is your faith?		

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (*circle any that apply and list family member, e.g. sibling parent, uncle, etc.*)

Difficulty	Yes	No	Family member
Depression	**Yes**	**No**	
Bipolar disorder	**Yes**	**No**	
Anxiety disorder	**Yes**	**No**	
Panic attacks	**Yes**	**No**	
Schizophrenia	**Yes**	**No**	
Alcohol/substance misuse	**Yes**	**No**	
Eating disorders	**Yes**	**No**	
Learning disabilities	**Yes**	**No**	
Trauma history	**Yes**	**No**	
Suicide attempts	**Yes**	**No**	
Chronic illness	**Yes**	**No**	

OTHER INFORMATION

(Please feel free to leave blank if you are unsure at present)

What do you consider to be your strengths?
What do you like most about yourself?
What are effective coping strategies that you have learned
What are your goals for therapy?