Counselling Intake Form

Demographic Information:

Date:_____

Name:_____

Age:_____

Married/Single, Divorced, Separated, etc.,
Status?_____

Home/Mobile
Phone:_____

Is it ok to leave a message for you at this number, yes or
no?:_____

Email:_____
_____

Is it ok to email
you?:_____

Mailing
Address:_____

Current Occupational Status (i.e., self-employed, student,
etc):_____

Occupation/Postion
title?:_____

Emergency Contact Name &
Relationship/Phone:_____

Currently taking any medication/pain
control?:_____

Behavior - please specify or circle any of the following behaviors that apply to you:

overeat suicidal attempts take drugs insomnia withdrawal/avoidance

lack of motivation eating problems sleep disturbance

loss of control/self-esteem issues difficulty in intimate relationships
pain management self-efficacy communication difficulties

Feelings/Emotions - please specify or circle any of the following feelings/emotions that apply to you:

Angry Conflicted Content Guilty Restless Fearful
Relaxed Unhappy Sad Hopeful Annoyed

Happy Lonely Panicky Jealous Bored Anxious Helpless
Hopeless Optimistic Other: _____

What do you do in your spare time? (Hobbies, interests, etc).

Which of the following have you experienced in the past or currently? (you can circle or note them in the space provided)

Abuse, death of close friend/family member, drugs/alcohol misuse, concerns about eating, self-image difficulties, panic attacks, attempted suicide, sadness, difficulty with personal/intimate relationships, physical health or any other significant concerns.

Have you ever seen a therapist, counsellor or Social Worker in the past? Have you participated in counselling/therapy in the past?

Was it Helpful? If Yes, can you please indicate why it was or was not.

Goals for Therapy

What are your main concerns/issues? How long have you been concerned about this?

Do you have any concerns about being in therapy?