The following form is used for intake purposes. The intention is to gather contact information and important details that can help the therapeutic process. Please take a moment to read each question and answer to the best of your knowledge. It should only take approximately 15-20 minutes.

Today's date: _____

Name of person filling out form: _____
I am filling this form out for: ____ myself ____ someone else

If filling out for someone else, please describe your relationship to the client:

_____

Client information

Full Name: _____

Preferred/chosen name (if different): _____

Date of birth: _____ Sex: _____ Gender (if different): _____

Street address: _____
House number *street name*

_____
city province postal code

Phone number (incl. area code): _____ cell____ home____ work____

Email: _____

Name of guardian (if under 18): _____
Relationship to guardian: _____

Emergency contact name: _____ Relationship: _____
Emergency contact phone #: _____

This next section collects some information about the home environment. For parents/caregivers, please fill out information as it pertains to your child.

Are you being raised by your biological parents? ___yes ___no

Please share a little about who is raising you:

_____
_____
_____

Please share a little about your parent/caregiver's relationship – are they:
___married ___committed relationship/not married ___separated/ended relationship
___single parent home (mother) ___single parent home (father)

If parents/caregivers are no longer in relationship with each other, please share when the separation occurred:

_____

Please list any siblings and their ages:

_____
_____
_____

This next section asks for information about school, any employment (if applicable), and social activities that you may take part in

Please share what school you go to: _____
What grade are you in? _____ Have you ever repeated a grade?_____
What is your experience in school like?

_____
_____
_____

Do you have a job? ___yes ___no If yes, where? _____
How many hours a week do you work? _____

Please share about any social supports you have (sports, friends, hobbies, groups you belong to, extended family, church, etc.)

_____
_____

_____

_____

Did anyone suggest you reach out to us? If yes, why? Do you agree with them?

_____

_____

_____

This next section is about your physical health history

Do you have a family doctor/primary care physician? ___yes ___no
If yes, please list physician's name and phone number _____
If no, how do you take care of physical health concerns? _____

_____

Please share a little about the last time you went to the doctor:
When was it? _____
What was the purpose of the visit?

_____

_____

Please list any illnesses or concerns regarding your physical health

_____

_____

_____

Please list any medications you are taking and their dosage

Medication	*Dosage*	*Reason for prescription*

This next section asks for information about substances. Please check past use, present use, or none. Describe use (how often, how much).

Substance	***Use (please circle)***	***Describe***
alcohol	Past current none	

cigaretttes	Past current none	
e-cigs/vape	Past current none	
Marijuana/THC	Past current none	
CBD oil	Past current none	
cocaine	Past current none	
Ecstasy/MDMA	Past current none	
hallucinogens	Past current none	
amphetamines	Past current none	
opioids	Past current none	
Prescription or OTC	Past current none	
Others not listed (please list)	Past current none	

The next section asks questions about your mental health history

Have you ever received a mental health diagnosis? ___yes ___no
If yes, please describe diagnoses and when received:
_____
_____
_____
_____

Are you currently receiving mental health care outside of our services? ___yes ___no
If yes, please describe:
_____
_____
_____

Have you previously received counselling or mental health care? ___yes ___no
If yes, please describe your experience:
_____
_____
_____

Please share about any family members who (either currently or in the past) have struggled with mental health concerns, eating disorders, or substance use. If known, please include any treatment received:

_____

_____

_____

Please circle any of the following concerns that relate to why you are seeking help:

Suicidal thoughts/ideation	Thoughts of harming others	Self-harming behaviour
Depressed mood	Depressed mood	Anxiety
Mood swings/changes	Sadness	Sleeping too little
Sleeping too much	Grief/loss	Sexual problems
Social relationships	Indecisiveness	Spiritual concerns
Pornography	Alcohol abuse	School/career
Body image	Separation/divorce	Gender identity/sexuality
Strange/repetitive thoughts	Confidence	Unhappiness
Stress	Fears/phobias	Sleep issues
Fatigue/tiredness	Anger	Finances/money
Guilt/shame	Intimate relationships	Family issues
Loneliness	Substance abuse	Internet/smartphone abuse
Feeling inferior	Appetite/eating	Memory/concentration
Work/school		

Finally, please use this space to share why you are seeking help:

_____

_____

_____

_____

_____

_____