

CLIENT INTAKE FORM

Please provide the following information and answer the questions below. Please note:

Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

**Name**: Click or tap here to enter text.

(Last/First/Middle Initial)

**Name of parent/guardian (if under 18 years):**

Click or tap here to enter text.

(Last/First/Middle Initial)

**Birth Date**:

**Age:** Click or tap here to enter text.

**Sex:** Click or tap here to enter text.

**Ethnicity:** Click or tap here to enter text.

**Nationality:** Click or tap here to enter text.

**Marital Status:**

[ ]  Never Married [ ]  Domestic Partnership [ ]  Married [ ]  Separated

[ ]  Divorced [ ]  Widowed

**Please list any children/age(s):** Click or tap here to enter text.

**Address**: Click or tap here to enter text.

**Home Phone**: (Click or tap here to enter text. May we leave a message? [ ]  Yes[ ]  No

**Cell/Other Phone**: (Click or tap here to enter text.)May we leave a message? [ ]  Yes [ ]  No

**E-mail**:Click or tap here to enter text. May we email you? [ ]  Yes [ ]  No

**Referred by (if any):**

**Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?**

[ ]  No

[ ]  Yes, previous therapist/practitioner: Click or tap here to enter text.

**Are you currently taking any prescription medication?**

[ ]  No

[ ]  Yes

Please list: Click or tap here to enter text.

**Have you ever been prescribed psychiatric medication?**

[ ]  Yes

[ ]  No

Please list and provide dates: Click or tap here to enter text.

 GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. **How would you rate your current physical health?**

 *Poor* [ ]  *Unsatisfactory* [ ]  *Satisfactory* [ ]  *Good* [ ]  *Very good* [ ]

 Please list any specific health problems you are currently experiencing:

Click or tap here to enter text.

2. **How would you rate your current sleeping habits?**

*Poor* [ ]  *Unsatisfactory* [ ]  *Satisfactory* [ ]  *Good* [ ]  *Very good* [ ]

Please list any specific sleep problems you are currently experiencing:

Click or tap here to enter text.

3. **How many times per week do you generally exercise?** Click or tap here to enter text.

What types of exercise do you participate in? Click or tap here to enter text.

4**. Please list any difficulties you experience with your appetite or eating patterns:**

Click or tap here to enter text.

5. **Are you currently experiencing overwhelming sadness, grief or depression?**

[ ]  No

[ ]  Yes

If yes, for approximately how long? 20 years

 6. **Are you currently experiencing anxiety, panic attacks or have any phobias?**

[ ]  No

[ ]  Yes

If yes, when did you begin experiencing this? Occurs constantly.

7. **Are you currently experiencing any chronic pain?**

[ ]  No

[ ]  Yes

If yes, please describe Headaches.

8. **Do you drink alcohol more than once a week?** [ ]  No [ ]  Yes

9. **How often do you engage recreational drug use?** [ ]  Daily[ ]  Weekly [ ]  Monthly

[ ]  Infrequently [ ]  Never

10. **Are you currently in a romantic relationship?**[ ]  No [ ]  Yes

If yes, for how long?

On a scale of 1-10, how would you rate your relationship? Click or tap here to enter text.

11. **What significant life changes or stressful events have you experienced recently?**

**FAMILY MENTAL HEALTH HISTORY**:

In the section below identify if there is a family history of any of the following. If yes,

please indicate the family member’s relationship to you in the space provided (father,

grandmother, uncle, etc.).

 Please Circle List Family Member

Alcohol/Substance Abuse *yes* [ ]  *no* [ ]  Father

Anxiety *yes* [ ]  *no* [ ]

Depression *yes* [ ]  *no* [ ]

Domestic Violence *yes* [ ]  *no* [ ]  Father

Eating Disorders *yes* [ ]  *no* [ ]

Obesity *yes* [ ]  *no* [ ]

Obsessive Compulsive Behaviour *yes* [ ]  *no* [ ]

Schizophrenia *yes* [ ]  *no* [ ]

Suicide Attempts *yes* [ ]  *no* [ ]

**ADDITIONAL INFORMATION:**

Highest Education Level:

[ ]  Doctorate

[ ]  Masters

[ ]  Bachelors

[ ]  Associates

[ ]  Secondary

[ ]  Primary

1. **Are you currently employed?** [ ]  No [ ]  Yes

If yes, what is your current employment situation?

Click or tap here to enter text.

**Do you enjoy your work? Is there anything stressful about your current work?**

Click or tap here to enter text.

2. **Do you consider yourself to be spiritual or religious?** [ ]  No [ ]  Yes

If yes, describe your faith or belief:

Click or tap here to enter text.

3. **What do you consider to be some of your strengths?**

4. **What do you consider to be some of your weakness?**

5. **What would you like to accomplish out of your time in therapy?**

Click or tap here to enter text.

**CLIENT RIGHTS & RESPONSIBILITIES**

**Clients have a right to:**

* Receive services in a professional, courteous and caring manner that respects and appreciates individual difference;
* Be provided with adequate and accurate information regarding the services provided in order to make informed choices about engaging in counselling;
* Receive counselling that is evidence-based, flexible and responsive to their individual needs and circumstances from properly qualified and supervised practitioners;
* Participate in, and contribute to, decision making in their care and management where appropriate;
* Expect that their personal privacy is respected, and confidentiality protected to the greatest extent permitted by law;
* The proper attention of the counsellor always throughout their counselling session.

**Clients have the responsibility to:**

* Be respectful to Counsellors and other On the Line staff;
* Avoid recording or disseminating material obtained during contact with a Counsellor; and
* Avoid using the service for a purpose for which it was not intended.

**To the best of their ability, and according to their circumstances, clients:**

* Must provide accurate information necessary for the provision of service;
* Must engage with services when in a fit state (i.e. not under the influence of drugs or alcohol);
* Should follow the reasonable instructions of the Counsellor in managing their safety and the safety of others

**NB: Referral will become necessary if the issue(s) presented go beyond the Counsellor’s scope of competence.**

**LIMITS TO CONFIDENTIALITY**

Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian. Noted exceptions are as follows:

**Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Minors/Guardianship**

 Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.

***I agree to the above limits of confidentiality and understand their meanings and ramifications.***

\*

**Client Signature (Client’s Parent/Guardian if under 18)**

Click or tap here to enter text.

**Counsellor’s Signature**

Click or tap here to enter text.

**Today’s Date**