InnerVision Counselling
Connected Compassionate Care

Individual Counselling Initial Intake Form

Date:_____

Personal Information

Full Name_____

Date of Birth (M/D/Y)_____ Current Age_____

Address_____City_____Province_____

Postal Code_____ Email Address_____

Phone Numbers:

Daytime (_____)_____ Do I have your permission to leave a message here?_____

Evening (_____)_____ Do I have your permission to leave a message here?_____

Relationship Status: ☐ Single ☐ Married ☐ Common-law ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact_____Relationship_____Phone_____

Counselling Therapy Information

Have you ever been in counselling therapy before? ☐ Yes ☐ No

If yes, when?_____

Who did you see?_____

If yes, what did you find helpful?_____

_____

_____

What did you not find helpful?_____

_____

_____

What brings you to counseling now?_____

_____

Please indicate what you want to work on or change in counseling_____

_____

How motivated are you to work on these issues?_____

Is there any other information pertaining to our work together that you would like to share?_____

_____

_____

Were you referred by someone else for counselling? ☐ Yes ☐ No Referral source:_____

Are you being compelled to come to counselling by someone else? ☐ Yes ☐ No By whom:_____

Physical/Medical/Mental Health History

Physician's name_____Location_____Phone_____

Overall physical health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current medical diagnosis / condition (if any)_____ Acute / Chronic

Current medications (prescription and non-prescription) _____

_____

Have you ever been hospitalized for a physical illness? Describe_____

_____

Have you ever been given a mental health diagnosis from a mental health professional? ☐ Yes ☐ No

If yes, please list diagnosis_____

How would you estimate the severity of the problem now? ☐ Mild ☐ Moderate ☐ Serious ☐ Severe

Have you ever been hospitalized for a mental illness? Describe_____

_____

Please circle any of the following symptoms that currently apply to you:

Headaches	Hypersomnia	Shortness of breath	burning/itchy skin
Appetite disturbances	Stomach trouble	Fatigue	Back pain
Sexual disturbances	Chest pains	Excessive sweating	Fainting
Bowel disturbances	Tremors	Anxiety	Blackouts
Twitches	Hearing things	Panic attacks	Hearing problems
Visual disturbances	Numbness	Dizziness	Weight concerns
Insomnia	Tingling		

Have you ever experienced ☐ physical abuse ☐ sexual abuse ☐ verbal abuse ☐ emotional abuse ☐ threats of abuse ☐ witnessed abuse of someone else ☐ stalking/harassment ☐ other_____

Have you ever had thoughts of suicide? When?_____

Do you currently have thoughts of suicide?_____

Have you ever attempted suicide?_____

Do you drink alcohol?_____ If yes, how much/often?_____

Do you smoke?_____ If yes, how much/how often?_____

Do you use drugs/substances of any kind for other than medical reasons?_____ If yes, what do you use and how often?_____

_____

Family History

Father Alive?_____ Where residing_____ How is your relationship?_____

If deceased, what year?_____ Cause of death_____

Mother Alive?_____ Where residing_____ How is your relationship?_____

If deceased, what year?_____ Cause of death_____

Parents' marital status?_____ If divorced/separated, what year?_____

Any step/foster parents?_____ If yes, how is your relationship with them?_____

Siblings? (indicate first name, age, and briefly describe how is your relationship with each of them)

_____

_____

What is your ethnic background?_____ Is there any aspect of your ethnicity/culture that you would like to

discuss?_____

How long have you been married/with your partner (if applicable)?_____

How would you describe your relationship with your spouse or significant other?_____

Do you have any children? [if yes, indicate age(s)]_____

_____

Please indicate if anyone in your family history has struggled with or is currently struggling with any of the following by circling those which apply:

Depression	Bipolar Disorder	Schizophrenia	Eating Disorder
Anxiety Disorders	Panic Attacks	Alcoholism	Drug Abuse
Identity Disorders	Sexual Abuse	Physical Abuse	Mental/Emotional Abuse
Sleep Disorders	Personality Disorders	Phobias	Sexual Addictions

Other (s):_____ _____ _____

Spiritual / Religious History

Religious upbringing _____Present affiliation_____

It is an important part of your life? ☐ Yes ☐ No Why or why not?_____

_____

Employment/Education Information

☐ Employed Full-time ☐ Part-time ☐ Student ☐ Unemployed ☐ On Leave ☐ Self-Employed

Employer_____City_____Province_____

How long there_____ Job title_____

If currently on leave, please state reason(s)_____

Highest level of education completed: ☐ None ☐ Grade School (indicate last year completed)_____

☐ High-school Diploma ☐ Some post-secondary (indicate how many years)_____

☐ Completed post-secondary education (indicate Diploma/Degree received) _____

I certify that the above is correct, fulsome and pertinent information and is an accurate reflection of my current situation as I understand it to the best of my ability:

Signature_____ Date_____