Dr. Mehry Kianfar Counselling and Psychotherapy

CLIENT INTAKE FORM

Client Information

Name:	**Phone**:	
DOB (MM/DD/YY):	**Age**:	
Address:	**City**:	**Province**:
Email:	**Postal Code**:	
OHIP:	**Sex** (Required for OHIP coverage):	
Family Doctor:	**Family Doctor Phone**:	
Emergency Contact:	**Emergency Contact Phone**:	
Credit Card*:	**Exp Date**:	**CVV**:

* Credit card information is only collected in the event of a no-show. You will not be charged for your appointment

General and Mental Health History

Have you previously received any mental health services? Yes/No

If yes, please provide the name of your previous practitioner (optional):

Please summarize your mental and physical health and wellness, including any mental health or physical health diagnosis:

If you are currently taking (or have previously taken) any medications please specify:

Goals of Therapy

What are your top 2 goals for therapy?

What is your motivation for seeking counselling?

Who/What is important to you?