COUNSELLING SERVICES

Adult Intake Form

Name:			
Address:			
ID #		**Age:**	**DOB:**
Telephone Numbers:	**Home:**	**Work:**	**Cell:**
Can I Contact you by email? YES/NO		**Email:**	

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ◯ yes ◯ no

Have you had previous psychotherapy?
◯ no
◯ yes, with (previous therapist's name)_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ◯ yes ◯ no

If yes, please list: _____

Prescribed by: _____

COPE COUNSELLING TORONTO

7419 BYBROOK DRIVE, MISSISSAUGA ON L4T 3R3
WWW.COPECOUNSELLINGTT.ORG
INFO@COPECOUNSELLINGTT.ORG
647 807 2948
@COPE_COUNSELLING

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HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ◯ yes ◯ no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? ◯ yes ◯ no
If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: _____

_____

Are you currently on medication to manage a physical health concern? ◯ yes ◯ no If yes, please list: _____
_____

Are you having any problems with your sleep habits? ◯ yes ◯ no

If yes, check where applicable:
◯ Sleeping too little ◯ Sleeping too much ◯ Poor quality sleep
◯ Disturbing dreams ◯ other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ◯ no ◯ yes

If yes, check where applicable: ◯ Eating less ◯ Eating more ◯ Bingeing
◯ Restricting

Do you regularly use alcohol? ◯ no ◯ yes

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In a typical month, how often do you have 4 or more drinks in a 24 hour period?

_____

How often do you engage recreational drug use? ◯ daily ◯ weekly ◯ monthly ◯ rarely ◯ never

Do you smoke cigarettes or use other tobacco products? ◯ yes ◯ no

Have you had suicidal thoughts recently?
◯ frequently ◯ sometimes ◯ rarely ◯ never

Have you had them in the past?
◯ frequently ◯ sometimes ◯ rarely ◯ never

Are you currently in a romantic relationship? ◯ no ◯ yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship?
_____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: _____

_____

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Have you ever experienced any of the following?

Extreme depressed mood	☐ Yes/ ☐ No
Dramatic mood swings	☐ Yes/ ☐ No
Rapid speech	☐ Yes/ ☐ No
Extreme anxiety	☐ Yes/ ☐ No
Panic attacks	☐ Yes/ ☐ No
Phobias	☐ Yes/ ☐ No
Sleep disturbances	☐ Yes/ ☐ No
Hallucinations	☐ Yes/ ☐ No
Unexplained losses of time	☐ Yes/ ☐ No
Unexplained memory lapses	☐ Yes/ ☐ No
Alcohol/substance abuse	☐ Yes/ ☐ No
Frequent body complaints	☐ Yes/ ☐ No
Eating disorder	☐ Yes/ ☐ No
Body image problems	☐ Yes/ ☐ No
Repetitive thoughts (e.g. obsessions)	☐ Yes/ ☐ No
Repetitive behaviors (e.g. frequent checking, hand washing	☐ Yes/ ☐ No
Homicidal thoughts	☐ Yes/ ☐ No
Suicidal attempts	☐ Yes/ ☐ No

OCCUPATIONAL INFORMATION

Are you currently employed? ◯ no ◯ yes

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any _____

_____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ◯ no ◯ yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ◯ no ◯ yes

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	☐Yes/☐No	
Bipolar disorder	☐Yes/☐No	
Anxiety disorder	☐Yes/☐No	
Panic attacks	☐Yes/☐No	
Schizophrenia	☐Yes/☐No	
Alcohol/substance abuse	☐Yes/☐No	
Eating disorders	☐Yes/☐No	
Learning disabilities	☐Yes/☐No	
Trauma history	☐Yes/☐No	
Suicide attempts	☐Yes/☐No	
Chronic illness	☐Yes/☐No	

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OTHER INFORMATION

What do you consider to be your strengths? _____

_____

_____

What do you like most about yourself? _____

_____

What are your goals for therapy?

_____

_____

_____

_____

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