THERAPY INTAKE

Confidential Client Form

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CONFIDENTIAL

This form helps your therapist understand your concerns, history, strengths, safety needs, and goals.
You may leave non-required questions blank and discuss them during intake.
This form is not monitored for emergencies.

Therapy Intake Form

Client and emergency contact information

1. Client Information

First name *

Last name *

Preferred name

Date of birth *

Gender identity

Pronoun(s)

Sex

Email

Mobile phone

Home phone

Work / other phone

Street address

City

Postal code

2. Emergency Contact

Name

Relationship

Phone

Email

3. Presenting Concerns

Please describe what brings you to seek therapy at this time *

When did this issue first begin?

What areas of your life have been most affected?

What have you already tried to cope with or address this concern?

4. Current Safety and Crisis Screening

Current thoughts of self-harm or suicide: ○ No ○ Self-harm ○ Suicide ○ Both

Another current crisis or immediate safety concern? ○ Yes ○ No

If yes, provide details, current supports, and safety measures

5. Therapy Goals

What do you hope to achieve, accomplish, or change through therapy?

Short-term goals or immediate needs

Long-term goals or needs

6. Medical and Medication History

Do you currently take medication? ○ Yes ○ No

If yes, list medication, dosage, duration, prescriber, and side effects

Is your current medication effective? ○ Yes ○ No ○ Unsure ○ N/A

Difficulty managing medications, refills, or affordability? ○ Yes ○ No ○ Sometimes

6A. Additional Medical Information

Relevant medical conditions, allergies, injuries, chronic pain, hormonal concerns, or other health information

Medical providers, current investigations, or accommodations:

7. Nutrition and Sleep

Eating habits

Average sleep hours

Sleep difficulties? ○ Yes ○ No ○ Sometimes

Describe nutrition or sleep concerns that may affect your well-being

8. Mental Health History

Overall mental health rating

- ☐ Depression
- ☐ Anxiety
- ☐ ADHD / ADD
- ☐ Personality disorder
- ☐ Self-harm
- ☐ Suicidal thoughts
- ☐ Suicide attempt
- ☐ Trauma or loss
- ☐ Other

Diagnoses, symptoms, dates, assessments, hospitalizations, or other relevant information

9. Previous Counselling or Mental Health Support

Previous counselling or mental health support? ○ Yes ○ No

How helpful was it? ○ Very ○ Somewhat ○ Not at all ○ N/A

Describe previous approaches, what was helpful, and what was not helpful

10. Substance Use

- ☐ Alcohol
- ☐ Cannabis
- ☐ Heroin
- ☐ LSD / hallucinogens
- ☐ Stimulants
- ☐ Ecstasy
- ☐ Vaping
- ☐ Tobacco
- ☐ Cocaine / crack
- ☐ Amphetamines / crystal meth
- ☐ Pain medication
- ☐ Tranquilizers / sleeping medication
- ☐ Inhalants / solvents
- ☐ Other

Describe frequency, amount, current concerns, and impact on functioning

11. Substance Use Follow-Up

Have you felt you should reduce your use? ○ Yes ○ No ○ Prefer not ○ N/A

Has anyone expressed concern about your use? ○ Yes ○ No ○ Prefer not ○ N/A

Current or previous recovery program? ○ Yes ○ No

12. Family Mental Health History

- ☐ Parents / guardians
- ☐ Siblings
- ☐ Grandparents
- ☐ Aunts / uncles
- ☐ Cousins
- ☐ Other
- ☐ None known

Describe known family mental health or substance use history

Family member attempted or died by suicide? ○ Yes ○ No ○ Unsure ○ Prefer not

13. Social and Living History

Current living situation

Who do you live with?

- [ ] Employed full-time
- [ ] Employed part-time
- [ ] Unemployed
- [ ] Student
- [ ] Retired
- [ ] Other

Employment satisfaction

Additional information about employment, education, finances, or daily functioning

14. Cultural, Spiritual, Learning, and Accessibility Needs

Cultural, spiritual, religious, Indigenous, or community practices important to you

Preferred language

Interpreter required?

Learning, communication, sensory, cognitive, mobility, or accessibility needs

15. Important Relationships and Supports

Significant relationships, supports, or people who are important in your life

Overall relationship quality

Relationships to discuss?

16. Coping Skills, Strengths, and Stress Management

How do you typically cope with stress or difficult situations?

Personal strengths, interests, values, or supports that may help in therapy

Anything else you would like your therapist to know?

17. Funding Information

Primary funding source

Treaty number, if applicable

Other funding details

Would the full private fee limit access to therapy?

Yes No Unsure N/A

Need consideration for a sliding-fee space?

Yes No

18. Primary Private Insurance

Insurance company

Policy number

Member number

Group number

Policyholder name

Relationship

Policyholder DOB

Employer

19. Secondary Private Insurance

Insurance company

Policy number

Member number

Group number

Policyholder name

Relationship

Policyholder DOB

Employer

20. Insurance Verification

Pre-authorization required? ○ Yes ○ No ○ Unknown

Deductible before coverage begins? ○ Yes ○ No ○ Unknown

Deductible amount

Co-payment per session

Annual session or reimbursement limit? ○ Yes ○ No ○ Unknown

Number of sessions, annual dollar maximum, or other limits

21. Acknowledgement and Signature

- [ ] I confirm that the information provided is accurate to the best of my knowledge.
- [ ] I understand this intake form becomes part of my or my child's clinical record.
- [ ] I understand this form does not replace informed consent or a service agreement.
- [ ] I authorize release of information required to process insurance claims, where applicable.
- [ ] I understand urgent or emergency concerns must be directed to emergency or crisis services.
- [ ] I understand electronic transmission carries privacy and security risks that cannot be completely eliminated.

Client / guardian name *

Relationship to client

Electronic signature / typed name *

Date *

Submission instructions

Save the completed PDF and submit it using the secure method provided by STCC.

Do not email urgent or emergency information.

For questions: (204) 818-2609 | sandi@stcc.ca

This intake form does not replace informed consent, service agreements, or clinical assessment.

The therapist may follow up for clarification or additional safety screening.