



Intake Client Form

Date: / /

Main reason for seeking Counselling: _____

1. Contact Details (Leave right hand side questions blank if you would prefer to not answer)

Name: _____ Pronouns: (For example: She/Her) _____
Age: _____ Ethnicity: _____
Date of Birth: _____ Religion: _____
Address: _____ Gender: _____
Email: _____
Phone: _____

BACKGROUND INFORMATION

(Please check all that apply.)

Anger Management	Anxiety	Abuse/Violence
Depression	Inattentiveness	Self Esteem
Hyperactive	Trauma	Financial Stressors
Family Concerns	Withdrawn	Eating Disorder
Substance Abuse	Grief & Loss	Attachment Issues
Divorce/Separation	Sexuality/Homosexuality Concerns	Suicidal/Homicidal
Work/School-Related	Adoption/Foster-Care	Crisis Intervention
Transition Issues	Adjustment Issues	
Peer Issues	Sibling Rivalry	Relationship Concerns
Sleeping Problems	Chronic Pain/Illness	Recent Weight Loss/Weight Gain

4. Have you attended any counselling before?

NO / YES

5. What do you hope to achieve through accessing Counselling Services? List 3 Main Goals

- 1.
- 2.
- 3.

Diagnosis/ Medical History:

Have you previously been diagnosed with any mental health disorders by a professional ? If yes, list below, if not applicable leave blank

MEDICAL INFORMATION

Primary Care Physician _____ Phone _____

Psychiatrist _____ Phone _____

Description of past medical problems _____

Please list current medications/dosage

Reason Prescribed



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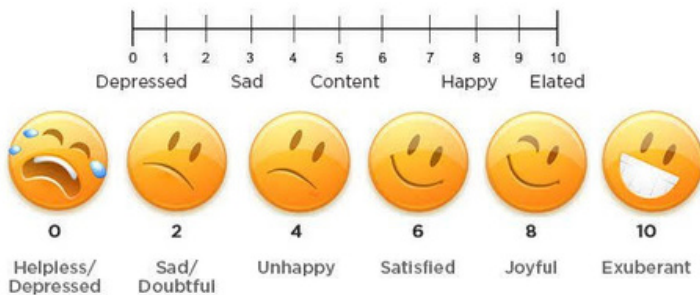
Please list below your preferred days and times for sessions:

Emergency Contact:

Name: _____ Relationship to Client: _____

Phone number: _____ Email: (if applicable) _____

Please input a number in relation to where you feel you are on the emotions scale currently:
(Refer to scale image below)



Please sign below to confirm that you have reviewed all documents provided including privacy policy, code of conduct and client rights, consent form, and you acknowledge acceptance of pricing list provided in line with requested appointment type and fee charged.

Client name:

Signature x _____

Date: / /