

Michelle Gilligan, MA, RCC

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Intake Information Name: _____ Date of Birth: _____ Telephone: Work: Cell: _____ (Please check box if ok to leave message at each number) Referral Source: Physician: Contact Number: Medication: Please notify in case of emergency: Name: Contact Number: 18 or younger: Father's name: _____ Contact Number: _____

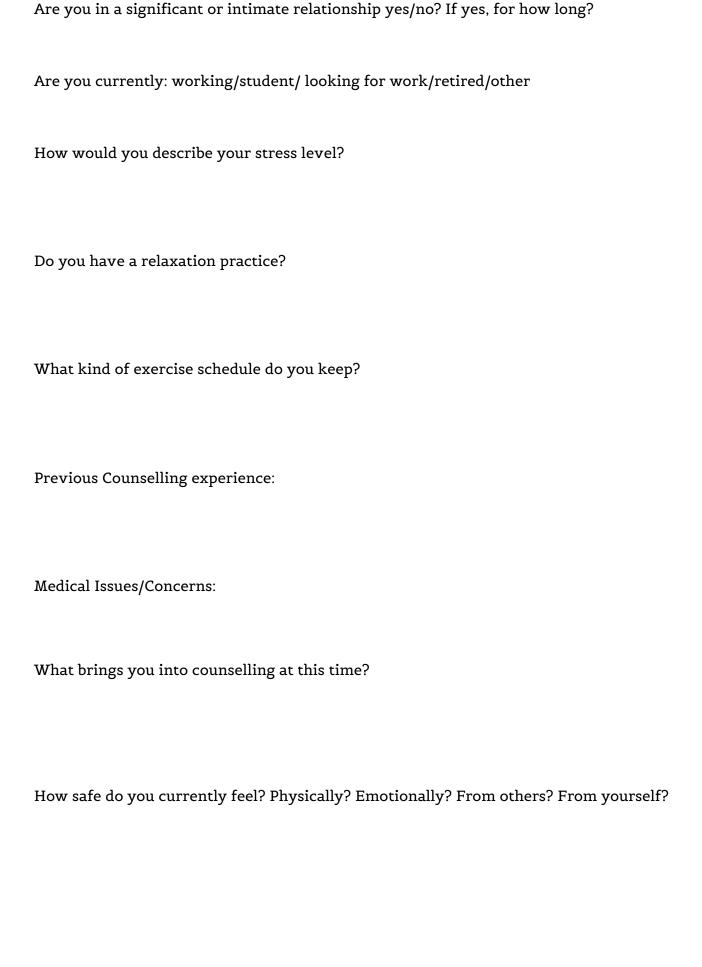
Mother's name: Contact Number:

Do you Experience: (please check any that apply and put a p for those that you've experienced in the past)

o depression	o reoccurring dreams or nightmares
o anxiety	o feeling out of control
o panic attacks	o high startle response
o post traumatic stress disorder	o irregular or painful menstruation
o difficulties sleeping (too much; too	o constipation/diarrhea
little; falling asleep;frequent waking)	o ulcers
o lethargy, exhaustion	o chronic pain
o outbursts of anger/rage	o migraines
o difficulties relaxing	o chronic fatigue syndrome
o overwhelmed	o fibromyalgia
o feelings of helplessness or being powerless	o autoimmune illnesses
o self-harming behaviours –	o heart disease
cutting/scratching/burning/other	o hypothyroidism/hyperthyroidism
o thoughts of death or dying	o other
o disordered eating	

Do you currently use any of the following (indicate how often, how much, and for how long):

Alcohol	Black tea
Tobacco	Marijuana
Coffee	Other substances
Soft drinks	



How do you cope? What are your strengths?
In what ways do you think counselling might help?
Is there anything else you would like me to know?