BADEN COVE COUNSELLING

# Counseling Intake Form

## Patient Name

First Name Last Name

## Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

## Cell Phone

## Home Phone

## Date of Birth

Month Day Year

## Email

example@example.com

**Pronouns: They or She/ Her or Him/He**

**Marital Status**

**Employment**

**Occupation**

**Primary Care Provider**

Name Phone Number

**Preferred Method of Contact**

- E-mail
- Home Phone
- Cell Phone
- Text Messaging

**Are you ok if we leave a message? (Home phone, cell phone, text message)**

- Yes
- No

**If yes, where is it ok to leave a voice mail, email, or text message?**

- Home Phone
- Cell Phone
- Text Message
- Email

**Type of Counselling Seeking:**

- Individual
- Couples
- Family
- Support Groups
- Other

Emergency Contact Information

## Name

First Name Last Name

## Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

## Phone Number

## Alternative Phone Number

## Relationship

Medical History

## Please check all the apply

- ☐ None
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Benign Prostatic Hypertrophy
- ☐ Blood Clots
- ☐ Cerebrovascular Accident
- ☐ COPD (Emphysema)
- ☐ Depression
- ☐ Gallbladder Disease
- ☐ Allergies
- ☐ Angina
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Cancer
- ☐ Cronary Artery Disease
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ GERD (Reflux)

- [ ] Hepatitis C
- [ ] Hypertension
- [ ] Liver Disease
- [ ] Myocardial Infarction
- [ ] Osteoporosis
- [ ] Renal Disease
- [ ] Thyroid Disease
- [ ] Hyperlipidemia
- [ ] Irritable Bowel Disease
- [ ] Migraine Headaches
- [ ] Osteoarthritis
- [ ] Peptic Ulcer Disease
- [ ] Seizure Disorder
- [ ] Other

**Do you use tobacco?**

- ○ No
- ○ Daily
- ○ Weekly
- ○ Less
- ○ Former User

**Do you use alcohol?**

- ○ No
- ○ Daily
- ○ Weekly
- ○ Less
- ○ Former User

**Caffeine use?**

- ○ No
- ○ Daily
- ○ Weekly
- ○ Less
- ○ Former User

**Have you or do you use drugs? (non-prescribed medication)**

- ○ Yes
- ○ No
- ○ Former User

**Please list:**

**Are you currently taking prescription medication?**

- ○ Yes
- ○ No

**Have you had any surgeries or hospitalizations in the past 5 years?**

- ○ Yes
- ○ No

**Please specify:**

**Family history**

- ☐ Adopted
- ☐ Allergies
- ☐ ArthritisBlood Disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Hearing Deficiency
- ☐ Hypertension (High Blood Pressure)
- ☐ Learning Disability
- ☐ Tuberculosis
- ☐ Osteoarthritis
- ☐ PVD
- ☐ Other
- ☐ Alcoholism
- ☐ Asthma
- ☐ CAD (Heart Attack)
- ☐ CVA (Stroke)
- ☐ Developmental Delay
- ☐ Eczema
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Irritable Bowel Disease
- ☐ Mental Illness
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Renal Disease

Mental Health History

**Why you are seeking counselling?**

**What do you expect / hope from counseling?**

**Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?**

- ○ Yes
- ○ No

**Average hours of sleep per night**

**Please describe any other experiences you have had that you feel is relevant.**

**Additional comments or concerns**

*Your signature below indicates that the information you have provided above is truthful.

**Date**

Month Day Year