

Date file opened:\_\_\_\_\_

Chart #:\_\_\_\_\_

## Counselling Intake Form

First name:\_\_\_\_\_ Last name:\_\_\_\_\_

Age:\_\_\_\_\_ DOB:\_\_\_\_\_

Ethnicity:\_\_\_\_\_ Religion:\_\_\_\_\_ Marital Status:\_\_\_\_\_

Sex/gender:\_\_\_\_\_ Number of children:\_\_\_\_\_ Ages of children:\_\_\_\_\_

Home address:\_\_\_\_\_

Who do you live with?\_\_\_\_\_

Contact number:\_\_\_\_\_

Email:\_\_\_\_\_

Name of emergency contact:\_\_\_\_\_ Phone:\_\_\_\_\_

### EMPLOYMENT INFORMATION:

☐ On sick leave, as of this date:\_\_\_\_\_ Return to work date:\_\_\_\_\_

☐ I was: ☐ Full-time or ☐ Part-time at:\_\_\_\_\_ Position:\_\_\_\_\_

☐ Full-time at :\_\_\_\_\_ Position:\_\_\_\_\_

☐ Part-time at:\_\_\_\_\_ Position:\_\_\_\_\_

☐ Not working because:\_\_\_\_\_

### COUNSELLING HISTORY

Have you had previous counselling: \_\_\_\_\_ Date:\_\_\_\_\_

Name of counsellor:\_\_\_\_\_

Reason for this appointment request today:\_\_\_\_\_

List any concerns you have:\_\_\_\_\_

Are you currently taking any medications?

☐ Yes what: \_\_\_\_\_ why:\_\_\_\_\_

☐ No

Have you ever thought about, or attempted suicide: ☐ Yes ☐ No

Has anyone in your family, or friends committed, or attempted suicide:

☐ Yes ☐ No

If yes who:\_\_\_\_\_