Okanagan Therapeutic Counselling

CLIENT INTAKE INFORMATION Date ____________________

CLIENT NAME ______________________________ AGE________ SEX M F

PHONE NUMBER ____________________ ____________________

ADDRESS ____

EMAIL ADDRESS ____

SOURCE OF REFERRAL ____

DATE OF BIRTH MONTH ____________ DAY ____________ YEAR ____________

MARITAL STATUS Single Married Separated Divorced Common-law Widow/er

Name of spouse: ____

ANY CHILDREN Yes No

Names / Ages ____________________ ____________________

____________________ ____________________

____________________ ____________________

LIVE ALONE Yes No ____

OCCUPATION ____

INCOME LEVEL ____________________ FAMILY INCOME LEVEL ____________________

CULTURAL BACKGROUND ____

RELIGIOUS AFFILIATION ____

FAMILY BACKGROUND **Parents' Names:** ____________________ ____________________

BIRTH ORDER OF SELF
& SIBLINGS (names & ages) ____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

MEDICAL HISTORY

FAMILY PHYSICIAN ____

ALLERGIES ____

CURRENT MEDICATIONS ____

(prescription or over-the-counter) ____

____________________ (turn page over)

PREVIOUS SURGERIES ____

____

CURRENT/ PAST DIAGNOSES ____

HEALTH PROBLEMS ____

____

____

HEREDITARY DISEASES ____

VENEREAL DISEASES ____

(previous or current)

ARE YOU CURRENTLY SEEING A COUNSELLOR OTHER THAN ME? Yes No

DO YOU CURRENTLY HAVE ANY THOUGHTS OF HARMING YOURSELF (Suicidal)? Yes No

DO YOU CURRENTLY HAVE ANY THOUGHTS OF HARMING ANOTHER (Homicidal)? Yes No

IS THERE ANY LEGAL CASE I SHOULD BE AWARE OF? Yes No

HAVE YOU HAD ANY INJURIES OR DIFFICULTIES OR PROBLEMS WITH:

Head &/or neck? Yes No Describe ______________________________

Breathing? Yes No Describe ______________________________

Heart /Circulatory system? Yes No Describe ______________________________

Urinary system? Yes No Describe ______________________________

Muscular /Skeletal problems? Yes No Describe ______________________________
Joint stiffness/weakness, Muscle Pain

Central nervous system problems? Yes No Describe ______________________________
Headaches, Shakiness, Convulsions, High Fevers

What do you want to accomplish in working with me?

What do you want to change about you or your life?

What are the unwanted feelings that are interfering in your life?