**thepsychotherapist COUNSELLING INTAKE FORM**

***thepsychotherapist*** is a private, independent, and confidential service designed to help you address your concerns and learn effective personal and interpersonal coping strategies.

**Note: This information is confidential.**

**DEMOGRAPHIC INFORMATION**

**Name:** Click or tap here to enter text.

**Date of Birth:** Click or tap to enter a date.

**Relationship status:** Choose an item.

**Gender:** Choose an item.

**Address:** Click or tap here to enter text.

**Contact no:** Click or tap here to enter text.

**Email address:** Click or tap here to enter text.

**Current employer:** Click or tap here to enter text.

**Current occupational status (please select one):** Choose an item.

**Emergency contact (name & relationship):** Click or tap here to enter text.

**Emergency contact phone:** Click or tap here to enter text.

**PERSONAL & FAMILIAL HISTORY**

**The following questions help me to understand you and the issues you are coming in to discuss. The more complete the forms are, the easier it is, and the less time we take in therapy to review them. If you do not wish to discuss an issue at this time, please feel free to leave it blank.**

How old was your mother and father at their marriage/when you were born?

Mother Click or tap here to enter text. Father Click or tap here to enter text.

If your parents are deceased, at what age and what was the cause?
Mother Click or tap here to enter text. Father Click or tap here to enter text.

How many brothers and sisters do/did your parents have, and where are they in birth order? Age at death if deceased? Click or tap here to enter text.

How was the childhood of your mother and father? Particular family or health issues?

Mother Click or tap here to enter text. Father Click or tap here to enter text.

Is there a history of any addictive or compulsive behaviour, psychiatric treatment, or depression in your parents’ family or with your parents?

Mother Click or tap here to enter text. Father Click or tap here to enter text.

How was/is your parent’s relationship with each other?

Click or tap here to enter text.

Are there divorces and remarriages with your parents?

Click or tap here to enter text.

How many children in your family? (Please provide gender and age)

 Click or tap here to enter text.

Genogram (completed by therapist):

Click or tap here to enter text.

How was your relationship with your family as you were growing up? What was it like to be your mother’s son/daughter?

Click or tap here to enter text.

What was it like to be your father’s son/daughter?

Click or tap here to enter text.

Siblings

Click or tap here to enter text.

Grandparents or others

Click or tap here to enter text.
Who would you go to for comfort?

Click or tap here to enter text.

To whom did you feel close?
Click or tap here to enter text.

How would you describe yourself as a child?

Click or tap here to enter text.

What was discipline like in your family?

Click or tap here to enter text.

How would you describe your family as you were growing up?

If you had to describe your “role” in the family, what would it be? For example, the peacemaker, the communicator, the parent, scapegoat.

Click or tap here to enter text.

Please describe your education

Click or tap here to enter text.

What was school like for you and what kind of student were you?

Click or tap here to enter text.

What were you like socially growing up?

Click or tap here to enter text.

**SPOUSE/PARTNER RELATIONSHIPS**

Relationship status?

Click or tap here to enter text.

How is your relationship with your partner?

Click or tap here to enter text.

Children? What are their names?

Click or tap here to enter text.

Comments:

Click or tap here to enter text.

Concerns?

### Click or tap here to enter text.

### *Behaviour – circle any of the following behaviors that apply to you:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ] Overeat | [ ]  Suicidal attempts | [ ]  Cannot keep a job | [ ]  Take drugs | [ ]  Compulsions |
| [ ] Insomnia | [ ]  Vomiting | [ ]  Smoke | [ ]  Take too many risks | [ ]  Odd behaviour |
| [ ]  Withdrawal | [ ]  Lack of motivation | [ ]  Drink too much | [ ]  Nervous tics | [ ]  Eating problems |
| [ ]  Work too hard | [ ]  Procrastination | [ ]  Sleep disturbance | [ ]  Crying | [ ]  Impulsive reactions |
| [ ]  Phobic avoidance | [ ]  Outbursts of temper | [ ]  Loss of control | [ ]  Aggressive behaviour | [ ]  Concentration difficulty |

Are there any specific behaviors, actions, habits that you would like to change?

Click or tap here to enter text.

### *Feelings – circle any of the following feelings that apply to you:*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| [ ] Angry | [ ] Guilty | [ ]  Unhappy | [ ]  Annoyed | [ ]  Happy | [ ]  Bored | [ ]  Sad |
| [ ]  Conflicted | [ ]  Restless | [ ]  Depressed | [ ]  Regretful | [ ]  Lonely | [ ]  Anxious | [ ]  Hopeless |
| [ ]  Contented | [ ]  Fearful | [ ]  Hopeful | [ ]  Excited | [ ]  Panicky | [ ]  Helpless | [ ]  Optimistic |
| [ ]  Energetic | [ ]  Relaxed | [ ]  Tense | [ ]  Envious | [ ]  Jealous | [ ]  Others: Click or tap here to enter text. |  |

### Physical – circle any of the following symptoms that apply to you:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Headaches | [ ]  Stomach trouble | [ ]  Skin problems | [ ]  Dizziness | [ ]  Tics |
| [ ]  Dry mouth | [ ]  Palpitations | [ ]  Fatigue | [ ]  Burning or itchy skin | [ ]  Muscle spasms |
| [ ]  Twitches | [ ]  Chest pains | [ ]  Tension | [ ]  Back pain | [ ]  Rapid heartbeat |
| [ ]  Sexual disturbances | [ ]  Tremors | [ ]  Unable to relax | [ ]  Fainting spells | [ ]  Blackouts |
| [ ]  Bowel disturbances | [ ]  Hear things | [ ]  Excessive sweating | [ ]  Tingling | [ ]  Watery eyes |
| [ ]  Visual disturbances | [ ]  Numbness | [ ]  Flushes | [ ]  Hearing problems | [ ]  Do not like touch |

**Check any of the following that apply to you:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Never** | **Rarely** | **Frequently** |  **Date of last use** |  | **Never** | **Rarely** | **Frequently** |
| Marijuana | [ ]  | [ ]  | [ ]  |  | Heart problems | [ ]  | [ ]  | [ ]  |
| Tranquilizers | [ ]  | [ ]  | [ ]  |  | Nausea | [ ]  | [ ]  | [ ]  |
| Sedatives | [ ]  | [ ]  | [ ]  |  | Vomiting | [ ]  | [ ]  | [ ]  |
| Aspirin | [ ]  | [ ]  | [ ]  |  | Insomnia | [ ]  | [ ]  | [ ]  |
| Cocaine | [ ]  | [ ]  | [ ]  |  | Headaches | [ ]  | [ ]  | [ ]  |
| Painkillers | [ ]  | [ ]  | [ ]  |  | Backaches | [ ]  | [ ]  | [ ]  |
| Alcohol | [ ]  | [ ]  | [ ]  |  | Early morning awakening | [ ]  | [ ]  | [ ]  |
| Coffee | [ ]  | [ ]  | [ ]  |  | Fitful sleep | [ ]  | [ ]  | [ ]  |
| Cigarettes | [ ]  | [ ]  | [ ]  |  | Binge / Purge | [ ]  | [ ]  | [ ]  |
| Narcotics | [ ]  | [ ]  | [ ]  |  | Poor appetite | [ ]  | [ ]  | [ ]  |
| Stimulants | [ ]  | [ ]  | [ ]  |  | Eat “junk foods” | [ ]  | [ ]  | [ ]  |
| Hallucinogens | [ ]  | [ ]  | [ ]  |  | Lack of interest in activities  | [ ]  | [ ]  | [ ]  |
| Diarrhea | [ ]  | [ ]  | [ ]  |  | Constipation | [ ]  | [ ]  | [ ]  |
| Compulsive Exercise | [ ]  | [ ]  | [ ]  |  | High blood pressure | [ ]  | [ ]  | [ ]  |
| Use Laxatives | [ ]  | [ ]  | [ ]  |  | Allergies | [ ]  | [ ]  | [ ]  |

**I have read, understood, and completed this questionnaire with accuracy and to the best of my knowledge.**

Name of Client: Click or tap here to enter text.

Client’s Signature: Click or tap here to enter text.

Date: Click or tap to enter a date.