Family Matters Plus Counselling Services

CLIENT INTAKE FORM

PRIVATE AND CONFIDENTIAL Date: ___________________

Name: ____

Date of Birth: ______/_______/__________ **(DD /MM / YYYY)** Age: ______ Gender: ____________

Nationality / Ethnicity: ____

Address: ____

City/Town: ____________________ Postal Code: _________________ Prov.: __________________

Cell phone: _________________________________ Home phone: ____________________________

Work phone: ____________________________ Email: _____________________________________

Best form of communication preferred: Home phone ☐ Cell phone ☐ Email ☐

May I leave message on your: Home phone ☐ Cell phone ☐ Email ☐

Highest education level completed: ____________________ Occupation: ____________________

Employment Situation

Unemployed ☐ Employed ☐ Self Employed ☐ Retired ☐

Employer: ____

Marital / Relationship Status

☐ In Relationship ☐ Engaged ☐ Single ☐ Married

☐ Separated ☐ Divorced ☐ Common law ☐ Widowed

Do you have children: ( ) Yes ( ) No If yes, how many: _______ Male ______ Female

Name of spouse/partner: ____ Age: ______

Years together: _____ Years married: _____ Nationality / Ethnicity: ________________________

Were you or your spouse/partner previously married / engaged? ( ) Yes ( ) No Years married/engaged: Yours: _______ Your Partner's: ________

Highest education level completed: ____

Employment Situation

Unemployed ☐ Employed ☐ Self Employed ☐ Retired ☐

Employer: ____

Referral Source (How did you find us)

Friend ☐ Family member ☐ Family doctor ☐ Lawyer ☐ HCS Website ☐ PsychologyToday

☐ Online: ____

Family / Household

Current living situation: ____

(People in Household)

	Name	***Relationship to you***	***Age***
1.			
2.			
3.			
4.			
5.			

Emergency Contact

Name: _____________________________________ Relationship: ____________________

Home Phone: _______________________________ Cell Phone: ______________________

Home Address: ____

Family of Origin (Are your parents still living)

Mother: ( ) Yes ( ) No Age: ____

If deceased, age at her death: _______ Known cause of death _________________________

Father: ( ) Yes ( ) No Age ____

If deceased, age at his death: _______ Known cause of death _________________________

Number of brothers/sisters: ________ Your birth order (e.g. oldest): ________________

Significant Personal Information

Have there been any significant events or losses in your life? ( ) Yes ( ) No

If yes, please specify…

Are you currently experiencing any of the following…

Eating disorder		Marital or Relationship difficulties	
Sleeping disorder		Parenting stresses	
Sexual dysfunction		Financial concerns	

Substance abuse - alcohol		Depression	
- drugs		Grief/Bereavement	
- prescription drugs		Anger	
- tobacco		Anxiety	
- other		Low Self Esteem	
Health (please list)		Trauma	
		PMS	
		Other:	

TREATMENT HISTORY

Do you have a Family Doctor? ( ) Yes ( ) No

Doctor's Name: ______________________________

Phone Number: ____________________ Fax Number: ____________________

Address: ______________________________

Are you presently taking prescribed medication? ( ) Yes ( ) No

Name of medication (.e.g. Tylenol)	For the treatment of (.e.g. headaches)

How would you describe your situation/concern and how have you dealt with it in the past?

Have you had previous counselling / psychotherapy treatment? ( ) Yes ( ) No

If yes, previous therapist's name: ______________________________

What was the focus of treatment: ______________________________

Duration of treatment: ____________________ Date of last visit: ____________________

Have you had one or more psychological assessment/tests in the past? ( ) Yes ( ) No Assessment was facilitated by: ______________________________ What was the assessment or test for: ______________________________

Please describe your previous counselling/psychotherapy experience?

What are your goals/expectations for counselling?

Spiritual Information

What is your faith / religion? ____

How would you describe your faith / religious practice or experience?

Are you open to developing your spirituality? ( ) Yes ( ) No

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate or extended) experienced difficulties with the following? (Tick all that apply and list family member, e.g. sibling, parent, uncle, etc.)

Difficulty	**Relationship**		
Alcohol/substance abuse		Yes ☐	No ☐
Anxiety disorder		Yes ☐	No ☐
Bipolar disorder		Yes ☐	No ☐
Borderline personality disorder		Yes ☐	No ☐
Chronic illness		Yes ☐	No ☐
Depression		Yes ☐	No ☐
Eating disorders		Yes ☐	No ☐
Learning disabilities		Yes ☐	No ☐
Panic attacks		Yes ☐	No ☐
Schizophrenia		Yes ☐	No ☐
Suicide attempts		Yes ☐	No ☐
Trauma history		Yes ☐	No ☐
		Yes ☐	No ☐
		Yes ☐	No ☐