**Company Name – Intake Form**

# Client Demographic Information:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Surname: |  | First Name: |  | | | |
| D.O.B. |  | Gender: | M | F |  |  |
| Relationship  Status: |  | # of  Dependents: |  | | | |
| Address: | | | | | | |
| Home Phone: | | Okay to Leave a Message-- Yes | | | No |  |
| Work Phone: | | Okay to Leave a Message-- Yes | | | No |  |
| Cell Phone: | | Okay to Leave a Message-- Yes | | | No |  |
| E-mail Address: | | Okay to Send a Message-- Yes | | | No |  |
| Emergency Contact: | | Relationship: | | |  |  |
| Emergency Contact Phone Number: | | | | | | |
| Current Employer: | | Position Title: | | |  |  |
| Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work): | | | | | | |
| Who Referred You: | | | | | | |
| Other Health Care Providers: (Names and Phone Number) | | | | | | |

# Current Concerns:

What concern brings you in?

What do you hope to accomplish in counselling?

Who are your supports when dealing with personal concerns?

# Mental Health:

# Have you ever been diagnosed with a mental illness?

If so, what is the diagnosis? When were you diagnosed?

Do you agree with the diagnosis?

Are you currently taking any prescription medications?

If so, what are the names and dosages?

# Behavior – Circle any of the following behaviors that apply to you:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Insomnia | Suicidal  Attempts | Avoiding  Activities | Using Drugs | Take too many  risks |
| Withdrawal | Isolation | Lack of  Motivation | Drink Too  Much | Work too hard |
| Procrastination | Sleep  Disturbance | Crying | Impulsive  Reactions | Phobic  Avoidance |
| Outbursts of Temper | Difficultly with Anger | Concentration Difficulties | Avoiding Family or  Friends | Missing Work/School |
| Eating Problems | OTHERS: |  |  |  |

**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 | Fearful |
| Hopeful | Excited | Panicky | Helpless | Optimistic |
| Energetic | Relaxed | Tense | Envious | Jealous |
| OTHERS: |  |  |  |  |

**Physical – Circle any of the following symptoms that apply to you:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Headaches | Stomach Trouble | Dizziness | Dry Mouth | Palpitations |
| Fatigue | Chest Pain | Muscle Tension | Back Pain | Rapid Heart Beat |
| Sexual Disturbances | Visual Disturbances | Bowel Disturbances | Increase or Loss of  Appetite | Hearing Things |
| Blackouts | Excessive  Sweating | Tingling | Unable to  Relax | Fainting Spells |
| OTHERS: |  |  |  |  |