STICK & STONE COUNSELLING SERVICES

ADULT INTAKE FORM

DATE: _____

GENERAL INFORMATION

LAST NAME: _____ FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

D.O.B: _____ AGE: _____ M / F Click HOSP. # _____

CELL PHONE: _____ EMAIL: _____

FAMILY INFORMATION

SINGLE ☐ DATING ☐ COMMON-LAW ☐ ENGAGED ☐

MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐

NAME OF SPOUSE/PARTNER: _____ TIME TOGETHER: _____

NAME OF CHILD/CHILDREN:	AGE:	D.O.B:	SCHOOL ATTENDED:

FAITH: (Please circle)

AGNOSTIC ☐ ATHEIST ☐ CHRISTIAN ☐ HINDU ☐ JEWISH ☐ MUSLIM ☐ OTHER ☐

Would you like faith incorporated into your treatment plan? **Y/N** Click

COUNSELLING/MEDICAL HISTORY:

Have you ever been involved in therapy or any type of counselling program? **Y / N** Click

If yes, when? _____ Where? _____

Reasons: _____

Are you in treatment with another counsellor at this time? **Y / N** Click

If yes, with whom? _____

Have you ever been hospitalized for any mental health issues/concerns? **Y / N** Click

If yes, when? _____

Have your ever been diagnosed with a mental health problem? **Y/N** Click

If YES, please explain: _____

_____

_____

Are you presently under a physician's care for your mental health? **Y / N** Click

Physician's Name: _____ Phone Number: _____

Are you presently under a psychiatrist's care for your mental health? **Y / N** Click

Psychiatrist's Name: _____ Phone Number: _____

Are you currently prescribed medication? **Y / N** Click If yes, what are you medicated for?

NAME:_____PRESCRIBED FOR: _____

NAME:_____PRESCRIBED FOR: _____

NAME:_____PRESCRIBED FOR: _____

NAME:_____PRESCRIBED FOR: _____

NAME:_____PRESCRIBED FOR: _____

Have you ever been, or are you currently being treated for any type of chemical dependency?

Y / N Click If yes, when? _____

By whom? _____Length of treatment? _____

Have you used any type of chemical substance? **Y / N** Click

If yes, please indicate what chemical substance you have used: _____

How frequently do you use these substances? (Please circle)

Daily ☐ Weekly ☐ Social ☐ Seldom ☐ Rarely ☐ Never ☐

How frequently do you consume alcohol? (Please circle)

Daily ☐ Weekly ☐ Social ☐ Seldom ☐ Rarely ☐ Never ☐

REASON FOR SEEKING COUNSELLING:

Are any of the following conditions a concern to you at this time: (Please circle all that apply)

☐ ANXIETY	☐ CHRONIC FEAR	☐ STRESS	☐ LOSS OF FAITH IN GOD
☐ GRIEF	☐ ANGER	☐ GUILT	☐ SPIRITUAL CONFLICT
☐ DEPRESSION	☐ RAGE	☐ SUICIDAL FEELINGS/THOUGHTS	☐ MARITAL PROBLEMS
☐ IRRATIONAL FEARS	☐ SELF-HARM BEHAVIORS	☐ LOSS OF EMPLOYMENT	☐ RELATIONSHIP WITH PARENTS
☐ NERVOUSNESS	☐ SUBSTANCE ABUSE	☐ LOSS OF HOPE	☐ RELATIONSHIP WTH CHILDREN
☐ LONELINESS	☐ SELF-ESTEEM	☐ LOSS OF MEANING IN LIFE	☐ RELATIONSHIP WITH FRIENDS

If any of the following statements are true, please check the one(s) that apply:

_____ I have thoughts of harming myself or others

_____These thoughts occur frequently

_____ I dwell on these thoughts and wonder if I can control them

_____I have sought professional help for these thoughts and feelings in the past

On a scale of 1-10 (10 being high) please rate your level of anxiety over the past 2 weeks:

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

On a scale of 1-10 (10 being high) please rate your level of anxiety over the past 6 months:

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

On a scale of 1-10 (10 being high) please rate your overall well-being:

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

What is your primary reason for seeking counselling? _____

_____

_____

_____

_____

What do you expect from therapy? _____

_____

_____

_____

_____

How did you come to know of Stick & Stone Counselling Services? (Please circle)

Referral ☐ Website ☐ Google ☐ Other: _____

Thank you for taking the time to fill out this intake form. All information will be kept confidential.

If any questions or concerns arise, please feel free to discuss them with your counsellor.