



**ADULT
INTAKE FORM**

DATE: _____

GENERAL INFORMATION

LAST NAME: _____ FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

D.O.B: _____ AGE: _____ M / F 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:

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**

COUNSELLING/MEDICAL HISTORY:

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

If yes, when? _____ Where? _____

Reasons: _____

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

If yes, with whom? _____

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

If yes, when? _____

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

If YES, please explain: _____

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

Physician's Name: _____ Phone Number: _____

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

Psychiatrist's Name: _____ Phone Number: _____

Are you currently prescribed medication? **Y / N** 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 If yes, when? _____

By whom? _____ Length of treatment? _____

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

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.