



DATE: _____

CLIENT:

LAST NAME: _____

FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____

PROVINCE: _____ POSTAL CODE: _____

D.O.B: _____ AGE: _____

M / F RACE: _____

PARENT/LEGAL GUARDIAN 1:

LAST NAME: _____

FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____

PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____

CELL PHONE: _____

EMAIL: _____

RELATIONSHIP TO CLIENT: _____

PARENT/LEGAL GUARDIAN 2:

LAST NAME: _____

FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____

PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____

CELL PHONE: _____

EMAIL: _____

RELATIONSHIP TO CLIENT: _____

CUSTODY ARRANGMENT (Please circle)

JOINT CUSTODY SOLE CUSTODY LEGAL GUARDIAN LEGAL GUARDIAN(S)

IS THERE A COURT ORDER? **Y/N**

DO BOTH PARENTS/GUARDIANS AGREE TO COUNSELLING FOR THE CHILD/ADOLESCENT? **Y/N**

If NO, please explain: _____

PHYSICIAN CARE

Is your child presently under a physician's care for their mental health? **Y/N**

Physician's Name: _____ Phone Number: _____

Has your child ever been diagnosed with a mental health problem? **Y/N**

If YES, please explain: _____

Is your child currently prescribed medications? **Y/N** If yes, what are they medicated for?

NAME: _____ PERSCRIBED FOR: _____

NAME: _____ PERSCRIBED FOR: _____

NAME: _____ PERSCRIBED FOR: _____

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 THOUGHTS/FEELINGS	UNHEALTHY WAYS OF COPING
IRRATIONAL FEARS	SELF-HARM BEHAVIORS	BEHAVIORAL PROBLEMS	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

What is your reason for seeking counselling? _____

What do you expect from therapy? _____

FAITH: (Please circle)

ATHEIST AGNOSTIC CHRISTIAN JEWISH MUSLIM HINDU OTHER

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

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.