She Counselling & Consulting Inc.

Intake Form:

Date: _____ Referral Source: _____

Last Name: _____ First: _____DOB: _____

Address: _____

Telephone: _____ Cell: _____ Work: _____

Email: _____

By initialing here, you are giving permission to receive confirmation emails to the provided email address ☐. * Please be aware that email may not be confidential.

Emergency Contact:
Name: _____ Relationship: _____
Contact Number: _____

Name of Insurance provider: _____
* If different then above, please list name as registered with your insurance provider: _____.

Please provide the name and contact information for your primary care physician/nurse practitioner:

_____

Current Marital Status:
☐ Single ☐ Married ☐ Separated/Divorced ☐ Widow

What has brought you in for counselling at this time?

_____
_____
_____
_____
_____.

Please describe how this problem interferes with your daily functioning. In what areas?

_____
_____
_____
_____
_____.

Please describe any major life changes or crisis in the last 12 months and how you dealt with them:

_____
_____
_____
_____
_____.

Are you currently taking any prescribed or over the counter medication? If so please list:

_____
_____
_____
_____.

Please list any new or longstanding physical or mental health diagnosis:

_____
_____
_____
_____.

Please check any that apply to now or in the past:

☐ Depression	☐ Anxiety	☐ Panic attacks
☐ Anger	☐ Stress	☐ Grief/loss
☐ Trauma	☐ Abuse	☐ Eating Disorder
☐ Mood swings	☐ Low Energy	☐ Social Difficulties
☐ Work problems	☐ Guilt	☐ Unusual thoughts
☐ Custody Issues	☐ Legal problems	☐ Addictions

Are you currently, or have you experienced suicidal thoughts, gestures, or attempts in the past? Please list:

_____
_____
_____
_____.

Has a relative or friend committed suicide?(Please give details)

_____
_____.

Have you or are you experiencing any homicidal thoughts? If yes, please explain:

_____
_____
_____.

Support System:
Name: Relationship: Length Known:

_____
_____
_____
_____
_____.

Previous experience with therapy: ☐ Yes ☐ No
If yes, please give the following details:

Name:	Date/Duration	Issue Addressed

What worked or didn't work with your previous experience(s)?

_____
_____

_____
_____.

What do you consider to be your strengths?

_____
_____
_____.

What do you like most about yourself?

_____
_____.

What do you like most about your life, regardless of current situation?

_____
_____.

Please list effective coping strategies that you have previously learned:

_____
_____
_____
_____.

What are your goals for therapy?

_____
_____
_____
_____.

Once completed please bring with you to your first appointment. Once signed this completed form will be considered <u>confidential</u>. This paper copy will be secured in a lock filing cabinet for the duration of our therapeutic relationship. Further information on file contents can be found in the *She Counselling & Consulting Inc.* Privacy Policy.

Signature of Client_____ Date:_____