PATIENT/CLIENT INTAKE FORM

The following information needs to be gathered in order for us to formulate a safe and effective treatment plan for you. This information will be kept confidential and cannot be released without your written consent unless obliged by law. This information may be shared amongst other health information custodians or circle of care for the purpose of your health care. Please feel free to ask any questions about the information being requested.

Full Name		
Date of Birth (MM/DD/YYYY):		Gender: Male or Female
Cell Phone:	Home Phone:	Work Phone:
Email Address:		
Address:		Apt #:
City:	Province:	Postal Code:
Occupation:		
Marital Status:		
Who may we thank for referring you to our care?		
Emergency Contact Name:		
Phone Number:	Relationship:	
General Health Background:		
General Physician Name:		
Address:		Phone Number:
Please describe any current medical conditions you may suffer from:		
Are you currently on any medications?		
Additional Doctors Information:		
Name:		Specialty:
Location/Address:		Phone Number:
Name:		Specialty:
Location/Address:		Phone Number:
Previous Psychological Assessments:		
Date of Assessment:		
Tests and Questionnaires:		
Results:		
Date of Assessment:		

Tests and Questionnaires:		
Results:		
Previous Psychological Diagnostic:		
Year of Diagnostic:	Are you on Medication? YES or NO	
Causes:		
Treatment/Course of Action:		
What is the name of the medication you are on for treatment?		
Family Health History (Heredo-Colateral Antecedents):		
Personal	Illness: Year:	Hospitalization?
Parental Mother/Father	Illness: Year:	Hospitalization?
Environmental Characteristics:		
Social Network	Relatives: Friends: Coworkers: Acquaintances:	
Spare Time Activities	Beside Profession or Work: Hobbies: Passions or Likes:	
Family Environment	Finances Home/Habitat Previous family events that may have affected you in the past or are still affecting you:	
Family Relationships	Conflict in Relationship With: Non-Conflict in Relationship with:	
Current Issue:		
Please describe to the best of your knowledge what brings you in today to seek help in the area of counselling and psychotherapy services.		
What do you want to see accomplished during psychotherapy sessions and as a result of the sessions?		

Client Name (Printed): ____

Client Signature: ____ Date: ______________