ChangeLife Counselling

Yelitza Cuevas, Toronto ON M6K 0A1 | 416 629.0348 | ChangeLifeCounselling@gmail.com

CLIENT INTAKE FORM

Welcome. I would like to make the most of each appointment you have with me. One way of doing this is for you to write down some basic information in advance of your first appointment. This information is confidential and will only be used for the purpose of adequately assessing your situation and selecting the most appropriate supports and services. **If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.** Please fill out the below form sections as completely as possible.

DATE

FIRST NAME | LAST NAME

AGE/DATE OF BIRTH | RELATIONSHIP STATUS

ADDRESS

HOME PHONE | WORK PHONE

CELL PHONE | EMAIL

IS IT OKAY TO LEAVE A VOICE MESSAGE FOR YOU AT INDICATED NUMBER(S)

YES ☐ NO ☐

IS IT OKAY TO CONTACT YOU VIA EMAIL

YES ☐ NO ☐

EMERGENCY CONTACT NAME

EMERGENCY CONTACT TELEPHONE | EMERGENCY CONTACT RELATIONSHIP

HIGHEST LEVEL OF EDUCATION | CURRENT CAREER/OCCUPATION

CAREER SATISFACTION

YES ☐ NO ☐ I feel stuck and am thinking about change

OTHER

HOBBIES, INTERESTS

LANGUAGES SPOKEN | HOW WERE YOU REFERRED

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PRESENTING PROBLEM

In your own words, please describe the nature of the concern that you wish to address in therapy at this time? Feel free to describe this in as much or as little detail as you wish.

1. PLEASE EXPLAIN WHAT BRINGS YOU HERE TODAY - WHY YOU DECIDED TO COME FOR THERAPY?

2. WHAT IS THE NATURE OF YOUR SITUATION (INDICATE ANY DILEMMAS/DIFFICULTIES/STRESSORS/CONCERNS THAT YOU WOULD LIKE TO DISCUSS IN THERAPY?

3. HOW LONG HAS THE PROBLEM BEEN GOING ON? IS IT GETTING BETTER OR WORSE NOW? HOW?

4. HAVE YOU TALKED TO SOMEONE ABOUT IT?

5. WHAT WOULD BE YOUR GOAL REGARDING YOUR PRESENTING PROBLEM (WHAT DO YOU HOPE TO ACCOMPLISH FORM COUNSELLING/THERAPY)?

6. IS THERE ANYTHING ELSE YOU WANT ME TO KNOW ABOUT (PERSONAL HISTORY YOU CONSIDER RELEVANT AND/OR MAJOR LIFE EVENTS?

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HEALTH HISTORY

HOW IS YOUR GENERAL HEALTH?

ANY CURRENT HEALTH CONCERNS?

ARE YOU NOW UNDER A DOCTOR'S CARE?

YES _____ NO _____ IF YES, NAME OF DOCTOR:

REASON FOR DOCTOR'S CARE

ARE YOU TAKING ANY MEDICATION?

YES _____ NO _____ IF YES, WHAT KIND OF MEDICATION

THE DATE OF YOUR LAST MEDICAL EXAMINATION

HAVE YOU EVER BEEN HOSPITALIZED FOR A PHYSICAL ILLNESS?

YES _____ NO _____ IF YES, DESCRIBE

HAVE YOU EVER BEEN HOSPITALIZED FOR A PSYCHOLOGICAL DIFFICULTY?

YES _____ NO _____ IF YES, DESCRIBE

ANY RECENT MAJOR ILLNESSES OR SURGERIES?

ANY RECURRENT OR CHRONIC CONDITIONS?

DO YOU SMOKE?

YES _____ NO _____ IF YES, HOW MUCH

DO YOU DRINK?

YES _____ NO _____ IF YES, HOW MUCH

DO YOU TAKE DRUGS?

YES _____ NO _____ IF YES, WHAT KIND

DID YOU HAVE WHAT YOU WOULD CONSIDER TO BE CHILDHOOD OR OTHER TRAUMAS?

YES _____ NO _____ IF YES, DESCRIBE

HAVE YOU EVER BEEN SUPPORTED FOR EMOTIONAL STRUGGLES IN A HOSPITAL ENVIRONMENT?

YES _____ NO _____ IF YES, WHEN

HAVE YOU HAD ANY THOUGHTS OF SUICIDE?

YES _____ NO _____ IF YES, WHEN

DO YOU HAVE ANY PREVIOUS THERAPY/COUNSELING EXPERIENCE?

YES _____ NO _____ IF YES, DESCRIBE WHEN, WHERE, HOW LONG YOU HAVE BEEN SEEING A THERAPIST

WHAT WAS THE NATURE OF THE DIFFICULTY AT THE TIME?

TYPE OF THERAPY?

FOCUS OF THERAPY?

WHAT WORKED, WHAT DID NOT WORK?

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CURRENT SAFETY

IS THERE A CURRENT CONCERN ABOUT ALCOHOL, DRUG ABUSE OR OVERUSE OF NON-PRESCRIBED DRUGS/MEDICATIONS?

PLEASE EXPLAIN:

IS THERE A CONCERN ABOUT VIOLENCE IN YOUR LIFE TODAY – EITHER FROM YOU OR TOWARDS YOU?

PLEASE EXPLAIN:

IS THERE ANY CONCERN ABOUT SUICIDE?

PLEASE ELABORATE:

ARE YOU CURRENTLY EXPERIENCING STRONG EMOTIONS?

IF YES, DESCRIBE

HOW CONCERNED ARE YOU ABOUT ANY OF THE AFOREMENTIONED ON A SCALE OF 1 TO 10 (10 BEING THE WORST)

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FAMILY HISTORY

PLACE OF BIRTH

MARITAL STATUS

HOW LONG HAV YOU BEEN IN THIS RELATIONSHIP

DO YOU LIVE TOGETHER?

HOW LONG HAVE YOU LIVED TOGETHER?

PARTNER'S NAME AND OCCUPATION

DESCRIBE RELATIONSHIP WITH YOUR PARTNER

NUMBER OF PREVIOUS MARRIAGES/RELATIONSHIPS

DO YOU HAVE CHILDREN? IF YES, THEIR SEX/AGE

HOW MANY SIBLINGS DO YOU HAVE? THEIR SEX/AGE

ANY EXPERIENCE WITH FAMILY ALCOHOLISM/DRUG ABUSE YES ____ NO ____

ANY EXPERIENCE WITH DOMESTIC VIOLENCE YES ____ NO ____

ANY EXPERIENCE WITH SEXUAL ADDICTIONS YES ____ NO ____

ANY EXPERIENCE WITH PHYSICAL OR MENTAL ABUSE YES ____ NO ____

ANY EXPERIENCE WITH SEXUAL ABUSE YES ____ NO ____

PARENTS: LIVING YES ____ NO ____

SIBLINGS: LIVING YES ____ NO ____

HOW WOULD YOU DESCRIBE YOUR RELATIONSHIP WITH PARENTS

HOW WOULD YOU DESCRIBE YOUR RELATIONSHIP WITH SIBLINGS

PARENTS DIVORCED? IF YES, WHAT YEAR

YOUR AGE AT THE TIME

IF PARENTS DECEASED, CAUSE OF DEATH AND WHAT YEAR

YOUR AGE AT THE TIME

ANY STEP-PARENTS? IF YES, DESCRIBE YOUR RELATIONSHIP WITH THEM

HOW WOULD YOU DESCRIBE YOUR SOCIAL NETWORK (Acquaintances, Friends, Intimates)

CLIENT-THERAPIST AGREEMENT

BY SIGNING BELOW, I AGREE TO GIVE 24 HOURS NOTICE IN THE EVENT THAT I CANNOT ATTEND A BOOKED APPOINTMENT IN ORDER TO AVOID BEING CHARGED FOR MISSED APPOINTMENTS. THIS IS DONE BY CONTACTING THE THERAPIST DIRECTLY BY TELEPHONE, TEXT MESSAGE OR BY EMAIL.

CLIENT SIGNATURE: _____ DATED at Toronto, this _____ day of _____, 20____.