2CONFIDENTIAL Counselling & Psychotherapy Intake (2022) Heather Macmillan, MEd, RCT, CCC

Name(s):_____**AGE:** _____

Date of Birth (Month/day/year): _____

Address: _____

CLIENT #: _____
INTAKE DATE:_____

_____

Preferred Communication: ❒ email ❒ tel.❒ text. Email address: _____
Telephone: (_____) _____-_____ **May I leave messages for you?** ❒Yes ❒No

Emergency Contact: _____**Telephone** _____
Relationship to Client: _____

Current gender identity (Check ALL that apply) ☐ Female ☐ Transgender Female/Transwoman/MTF
☐ Gender Queer ☐ Male ☐ Transgender Male/Transman/FTM
☐ Additional category (please specify): _____ ☐ Decline to answer

Current Family Situation
❒Single ❒Partnered ❒Married ❒Divorced ❒Separated ❒Blended ❒Widowed ❒Foster/Adoptive family
❒Children _____(names/ages)
Occupation/Employed/Unemployed/Underemployed: _____

Reason for seeking support at this time? _____

_____

_____

What changes would you like to see happen as a result of working together?

_____

_____

What contributes to the problem? What makes it worse?

_____

_____ _____

In the past, what have you done to try to cope with the problem?

_____

_____

Have you consulted a therapist before? ❒Yes ❒No Date)s)_____

How did you find out about my services?_____

Personal History ~ Please check any of the following that are concerns for you:

❒ Alcohol use	❒ Internet use/Virtual reality
❒ Anger/Irritability	❒ Suicidal thoughts/attempts
❒ Drug use	❒ Finances/Debt
❒ Anxiety/Panic	❒ Sleep difficulties
❒ Gambling	❒ Eating/Body image
❒ Depression/Low mood	❒ Gender identification
❒ Work difficulties	❒ Family conflict
❒ Stress	❒ Loss/Grief
❒ Self-esteem	❒ Sexual difficulties
❒ Historical assault or abuse (verbal/sexual/ physical)	❒ Chronic Illness/Pain/Surgery
❒ Motor vehicle collision/Accidents (recent/past)	❒ Recent assault or abuse (sexual/physical)
❒ Relationship difficulties	❒ Other (please specify)

Are you now or have you ever been exposed to:

Physical Violence	❒Current ❒Past	Sexual Abuse	❒Current ❒Past
Emotional/Verbal Abuse	❒Current ❒Past	Workplace Harassment	❒Current ❒Past
Family Addictions	❒Current ❒Past	Motor Vehicle Collision	❒Current ❒Past
Surgical trauma	❒Current ❒Past	Accident/injury	❒Current ❒Past

Other frightening or overwhelming experiences (simply name, no description necessary)

_____

_____

_____

Do you have a family doctor? ❒Yes ❒No (name/location): _____

Other health professionals actively involved in your healthcare? ❒Yes ❒N*o*

_____

Do you smoke? ❒Yes ❒No If so, what kind, how much per day/week? _____

Please list any medical diagnoses or health conditions:

_____

_____

Please list medications/supplements/other substances you are currently taking and for what reason:

_____

_____

Anything else you'd like to share that would better help me to understand you? _____

_____