Tina G Wellness

Counsellor & Life Coach

778-999-5301

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

Name: _____

(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender:

□ Male □ Female

Marital Status:

□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____

Local Address: _____(Street and Number)

_____ (City) (Prov/State) (Postcode/Zip)

Home Phone: ( ) _____ May we leave a message?

□ Yes □ No

Cell/Other Phone: ( ) _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

Referred by: _____

Are you currently receiving psychiatric services, professional counselling or psychotherapy elsewhere?

□ Yes □ No

Have you had previous psychotherapy?

□No □Yes, at Previous therapist's name _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

□Yes □No If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication?

□Yes □No If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

3. Are you having any problems with your sleep habits? □ No

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams

□ Other _____

4. How many times per week do you exercise? _____

Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits?

□ No □ Yes
If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting Have you experienced significant weight change in the last 2 months? □ No □ Yes

□ 6. Do you regularly use alcohol? □ No □ Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

7. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Rarely □ Never

8. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely
Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes
If yes, how long have you been in this relationship? _____
On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors:

Have you ever experienced:

Extreme depressed mood: □ No □ Yes Wild Mood Swings: □ No □ Yes Rapid Speech: □ No □ Yes
Extreme Anxiety: □ No □ Yes

Panic Attacks: □ No □ Yes
Phobias: □ No □ Yes
Sleep Disturbances: □ No □ Yes
Hallucinations: □ No □ Yes
Unexplained losses of time: □ No
Unexplained memory lapses: □ No
Alcohol/Substance Abuse: □ No
Frequent Body Complaints: □ No
Eating Disorder: □ No □ Yes

Body Image Problems: □ No □ Yes
Repetitive Thoughts (e.g., Obsessions) : □ No □ Yes Repetitive Behaviours (e.g., Frequent Checking, Hand-Washing) : Homicidal Thoughts: □ No □ Yes

Suicide Attempt: □ No □ Yes

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes
If yes, who is your current employer/position? _____ If yes, are you happy at your current position? _____ Please list any work-related stressors, if any: _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty

Family Member

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Depression: □ No
Bipolar Disorder:
Anxiety Disorders:
Panic Attacks: □ No □ Yes Schizophrenia: □ No □ Yes Alcohol/Substance Abuse: □ No Eating Disorders: □ No □ Yes Learning Disabilities: □ No □ Yes

Trauma History:

□ No

□ Yes

Suicide Attempts:

□ No

□ Yes

OTHER INFORMATION:

What do you consider to be your strengths? _____
_____
_____
_____

What do you like most about yourself? _____
_____
_____

What are effective coping strategies that you've learned? _____
_____
_____

What are your goals for therapy? _____
_____
_____

Emergencies:

If you require immediate support between sessions, please contact the crisis centre at 604-872-3311 BC Canada. If you experience an emergency, please contact 911.

Fees:

The fees for a 50 minute counselling session is …….. payable at the end of each session. Paypal or e-mail cash transfer is accepted. Receipts will be given for payment.

Cancellation:

Please contact me at 778-999-5301 or tinagutheridge@gmail.com in the event that you need to cancel or reschedule an appointment. Please provide 24 hours notice of a cancellation. Please not that if you arrive late you will have your session of the original session time and charged the full 50 minute session.

Confidentiality

In accordance with the Canadian Professional Counsellors Association, registered counsellors adhere to a strict Professional Standards of Practice and Professional Code of Ethics in maintaining confidentiality regarding your involvement in counselling.

Should you require your counsellor to communicate with another professional,written consent must be obtained prior to releasing any information.

There are exceptions to this confidentiality in situations where your counsellor:

1. Has evidence or strong suspicion of CHILD ABUSE

2. IF YOU ARE ASSESSED TO BE A DANGER TO YOURSELF OR OTHERS

3. If your counsellor or records are SUBPOENAED BY A COURT OF LAW.

…… …….

CLIENT DATE