RE-NOV8
COUNSELLING & PSYCHOTHERAPY

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CLIENT PROFILE (INTAKE)

This form is to aid your therapist assess your condition at the start of your therapy. You do not need to complete any session of this form if it makes you feel uncomfortable.

Personal Information

Name ______________________________

Date of Birth ______________ Gender: ______________

Email ______________________________

Address ______________________________

____

Home Phone ______________ Mobile ______________

Occupation ______________________________

Referred By ______________ Relationship to you ______________

Relationship

Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Engaged ☐ Partnered ☐ Children ☐

Emergency Contact

Name: ______________________________

Contact Phone ______________ Relationship to you ______________

Closest Relationships

(Please list name, birth date, relationship, and whether they live with you)

Name	Birth Date	Relationship	Living with you?

Please describe your current living arrangement *(Do you live with others?)*

____

____

____

____

____

Treatment/Medical Information

Have you participated in any therapy before? Yes ☐ No ☐

Reasons: ______________________________

Are you presently seeing a Psychologist or Counsellor? Yes ☐ No ☐

If Yes, list previous counsellor/psychologists

Name______________________________ Approx. dates seen ______________

Name______________________________ Approx. dates seen ______________

Have you or a family member ever been hospitalised for mental or emotional concerns?

Yes ☐ No ☐

If yes, specify details (condition, place and dates): ______________________________

____

Do you have a history of substance abuse / addiction?? Yes ☐ No ☐

If yes, specify details: -

____

____

____

Medical Information

Doctor's name and phone number

____

May we send your doctor a short note, letting him / her know you've come to see us? (We do not release details other than your name, for referral purposes) Yes ☐ No ☐

Are you on any medication? Yes ☐ No ☐

If yes, type of medication and purposes? ____

____

How can we help?

Please tell us in your own words what brings you here today:

____

____

____

____

What are your 2 most important goals for therapy?

1. ____
2. ____

Common problem/symptom checklist.

*(Fill in: **0** - none, **1** - mild, **2** - moderate, **3** - severe.)*

Marriage ____ Divorce/separation ____ Alcohol/drugs____ God/faith ____

Pre-marital_____Child custody _____ other addictions ____ Church ____

Being single _____ Disabled _____ grief/loss ____ past hurts ____

Sexual issues ____ work/career ____Depression ____ Co-dependency ____

Family ____ School/learning ____ Fear/anxiety ____ Intimacy ____ Children ____

Money/budgeting ____ Anger control ____ Communication ____ Parents ____

Aging/dependency ____ Loneliness ____ Self-esteem ____ In-laws ____

Weight control ____ Mood swings ____ Stress control ____ other ________________

Family Information

Marital Status (check any that apply):

Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐

Spouse's Name (if applicable) ____

Age ___________ Occupation ____

The following set of questions require a tick to the responses most applicable to your current situation.

I would describe my friendships as:

Close ___ Somewhat close____ Distant____ Conflicted____

I would describe my relationship with my mother as:

Close ___ Somewhat close____ Distant____ Conflicted____

I would describe my relationship with my father as:

Close ___ Somewhat close____ Distant____ Conflicted____

If any, how many siblings do you have? ____

How would you describe your relationship? _____________________________________

How would you describe your social life? ______________________________________

How would you describe your personality? _____________________________________

Crisis Information:

Are you having any current suicidal thoughts, feelings or actions?

Yes ☐ No ☐

Provide details ____

Any current homicidal or violent thoughts or feelings, or anger-control problems?

Yes ☐ No ☐

Provide details ____

Any issues, hospitalizations, or imprisonments for suicidal or assault behaviour?

Yes ☐ No ☐

If yes, describe ____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)?

Yes ☐ No ☐

If yes, describe ____

How did you hear about us?

____

Thank you for taking the time to fill out this information sheet. This will be reviewed with you during your first therapy session.