

INTAKE FORM

Name _____ Age _____ Date of Birth _____

Address _____

Phone Number _____ (best number to reach you at) Is it okay to leave messages?
 Yes No

Email address _____
 (if you are comfortable with this form of contact)

Emergency Contact _____
 Name & Relationship to you _____ Phone Number _____

Physician _____
 Name _____ Phone Number or Name of Clinic _____

Date of last check up or exam by a medical doctor _____

Do you have or have had any health concerns? Please check **F** for family members and **S** for self.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> <input type="checkbox"/> F S AD/HD | <input type="checkbox"/> <input type="checkbox"/> F S Chest Pain | <input type="checkbox"/> <input type="checkbox"/> F S Heart Trouble | <input type="checkbox"/> <input type="checkbox"/> F S Panic Attacks |
| <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> Chronic Pain or Fatigue | <input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Debilitating Injury | <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> <input type="checkbox"/> Anxiety | <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> Hyper/Hypo Glycemia | <input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Hyper/Hypo Thyroid | <input type="checkbox"/> <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Stomach or Digestive Problems |
| <input type="checkbox"/> <input type="checkbox"/> Autism | <input type="checkbox"/> <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Bi-Polar Disorder | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Lung Disease | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Borderline Disorder | <input type="checkbox"/> <input type="checkbox"/> FAS | <input type="checkbox"/> <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis | Other: _____ |

Please list any medications, vitamins, supplements, etc. and what you are taking them for:

Have you been in counselling before? Yes No If so, when _____

Please check any that apply:

	Present	Past
Feelings of sadness, crying, being down		
Racing thoughts		
Unwanted or intrusive thoughts		
Times when I can't control what I do		
Sleep problems		
Feeling worthless		
Difficulty controlling my temper		
Eating problems		

	Present	Past
Concerns about sexuality		
Use of alcohol or drugs		
Doing things over and over		
Seeing or hearing things that other's don't		
Feeling anxious or nervous		
Pain or health concerns		
Spiritual concerns		
Some things are too painful to talk about		

Being human involves your physical body, your mind and emotions, your spirit, and your relationships. On the next page, please rate these aspects of your life on a scale of 1 (poor) to 10 (excellent). Click on the line to indicate if you are closer to poor, average, or excellent. *Please note, there are no right or wrong answers—only your experience.*

PHYSICAL HEALTH

Do you feel healthy? 1 _____ 10
Near death's door Never better

Regular Exercise 1 _____ 10

Sleep Patterns 1 _____ 10

Nutrition 1 _____ 10

MENTAL/EMOTIONAL

Thought Patterns 1 _____ 10
Glass empty "Life sucks" Glass half empty Glass half full Glass full "Life's a beach!"

Emotionally I feel... 1 _____ 10
Distraught, out-of-control, dead A lot of strong emotions Balanced, stable, alive

Coping Strategies (manage daily life/stress with the help of...) Check or add any that apply:

<input type="checkbox"/> Medications	<input type="checkbox"/> Smoking/Tobacco	<input type="checkbox"/> Sex	<input type="checkbox"/> Family / Friends	<input type="checkbox"/> Caffeine	<input type="checkbox"/> Internet	<input type="checkbox"/> Video/Computer games
<input type="checkbox"/> Drugs	<input type="checkbox"/> Violent behaviour	<input type="checkbox"/> Sports	<input type="checkbox"/> "Retail therapy"	<input type="checkbox"/> Exercise	<input type="checkbox"/> Work	<input type="checkbox"/> TV/Movies
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Sleep a lot	<input type="checkbox"/> Food	<input type="checkbox"/> Faith/Church	<input type="checkbox"/> Music	Other: _____	

SPIRITUAL

Spiritually I feel... 1 _____ 10
Empty Confused Fulfilled

What "feeds your spirit"? (hobbies, art, music, activities, groups, prayer, meditation, Scriptures, church, etc.)

SOCIAL (RELATIONSHIPS)

Relationships are strained excellent

Friends 1 _____ 10

Family of origin (parents, siblings) 1 _____ 10

Nuclear family (partner, children) N/A 1 _____ 10

Workplace/School 1 _____ 10

Comments:

OVERALL

<input type="checkbox"/> I feel like a well-adjusted/well-connected person.	<input type="checkbox"/> I do alright but have some areas of concern.
<input type="checkbox"/> I'm functioning but just barely.	<input type="checkbox"/> I'm a complete mess.
<input type="checkbox"/> I am most concerned about _____	

How did you hear about me? Referred by _____ Advertisement Website Other _____

Thank you for taking the time to complete this form.
Feel free to call me with any questions or concerns, or mention them when we meet.