

### CLIENT INTAKE FORM

<b>Self:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>Partner:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Surname</b>			
<b>First Name</b>			
<b>Date of Birth</b>	Mm/dd/yy	Mm/dd/yy	
<b>Address</b>			
<b>Postal Code</b>			
<b>Home Phone</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Message OK?</b>		
<b>Work Phone</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Message OK?</b>		
<b>Alternative #</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Message OK?</b>		
<b>Employment</b>	<input type="checkbox"/> Fulltime Employed <input type="checkbox"/> PT Employment <input type="checkbox"/> Retired/Disability <input type="checkbox"/> Self-Employed <input type="checkbox"/> Social Assistance <input type="checkbox"/> Employment Insurance <input type="checkbox"/> Homemaker <input type="checkbox"/> Student	<input type="checkbox"/> Fulltime Employed <input type="checkbox"/> PT Employment <input type="checkbox"/> Retired/Disability <input type="checkbox"/> Self-Employed <input type="checkbox"/> Social Assistance <input type="checkbox"/> Employment Insurance <input type="checkbox"/> Homemaker <input type="checkbox"/> Student	
<b>Occupation/ Profession</b>	Title/Employer	Title/Employer	
<b>Ethnicity Identification</b>	<input type="checkbox"/> Canadian <input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Canadian <input type="checkbox"/> Other (Specify)	
<b>Religious Affiliation</b>	<input type="checkbox"/> Practicing (optional-Church/Faith): _____ <input type="checkbox"/> Non-Practicing	<input type="checkbox"/> Practicing (optional – church/faith): _____ <input type="checkbox"/> Non-Practicing	

**Educational**

**Level:** (Self):  None  Grades 1-4  Grades 5-8  Grades 8-12  College/University  
 (Spouse):  None  Grades 1-4  Grades 5-8  Grades 8-12  College/University

**Children and Other Dependants in Home** (elders, pets, etc.) (complete on back if required)

Name	Relationship (son/daughter/step)	Date of Birth Mm/dd/yy

**Relationship status (Self):**

- Married  
  Cohabiting  
  Separated  
  Divorced  
  Single  
  Widowed

**Service for:**

- Self  
  Couple  
  Family  
  Other (specify) \_\_\_\_\_

**Referred by:**

- Self  
  Peer/Friend  
  Phone Book  
  Doctor  
  Other Client  
  Family  
 Internet  
 Yellow Pages  
 Word of Mouth  
 Agency  
 Other (specify) \_\_\_\_\_

**General Health Condition:**

<b>Family Physician:</b>	Tel.:		
<b>Medication/Dosage</b> (additional on back of page)			

**Previous Professional Mental Health Assistance:**

Name of Professional	
Dates (mm/yy)	
Reason for Service	
<b>History of abuse</b> <input type="checkbox"/> physical <input type="checkbox"/> emotional <input type="checkbox"/> sexual Alcohol use <input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> regularly <input type="checkbox"/> frequently <input type="checkbox"/> excessive Non-medicinal drug use <input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> regularly <input type="checkbox"/> frequently <input type="checkbox"/> excessive Suicide <input type="checkbox"/> none <input type="checkbox"/> thoughts <input type="checkbox"/> plan <input type="checkbox"/> means	
<b>Reason for present service:</b>	
_____	
_____	
_____	
<b>What I would like to change or Issues I want to address:</b>	
_____	
_____	
_____	