Turning Point
Youth and Family Counselling Services

Counsellor Name:_____

Client Intake Form

Message OK?

Name: _____ Home phone: _____ ☐
Address: _____ Work phone: _____ ☐
City: _____ Postal Code: _____ Cell phone: _____ ☐

E-mail (optional):

Preferred means of contact: _____

Date of Birth: _____ Sex: M ☐ F ☐

Marital Status: _____ Date of marriage:_____

Name of Spouse/Partner: _____

Names of children: _____ Sex: _____ Age: _____
_____ _____ _____
_____ _____ _____

Highest level of education: _____

Employment status: _____

Religious affiliation: Christian_____ Other_____ None_____

Have you ever seen a counsellor, psychologist or been treated by a psychiatrist?_____

The reason: _____

_____

What was helpful/ unhelpful about your previous counselling?: _____

_____

Reason for seeking counselling now?: _____

_____

Current level of stress: _____ Level of support: _____
(1 being low & 10 being high)

Name of Doctor: _____ Date of last physical: _____

Address: _____ Phone: _____

Describe any current medical conditions: _____

_____

Current medication and dosage: _____

Any significant hospitalizations or traumas: _____

Have you experienced any concussions recently or in the past? _____ Date: _____

Have you had any of these symptoms in the last 6 months?

____ Increase/ decrease in appetite
____ Problems concentrating
____ Difficulty sleeping/insomnia
____ Low motivation
____ Sleeping too much
____ Isolating from others
____ Fatigue/low energy
____ Cycles of highs and lows
____ Frequent anger
____ Depressed mood/sadness
____ Tearful/crying spells
____ Anxiety/fear
____ Hopelessness/ worthlessness
____ Panic
____ Nightmares
____ Trembling or shaking
____ Muscle tension
____ Headaches
____ Dizzy or lightheaded
____ Chest pain
____ Stomach problems

Do you have any substance abuse or addictions? (smoking/ alcohol/ drugs/ food/ caffeine/ gambling/ sexual/ other)_____

Previous treatment for addiction? _____ Any family history of addiction?_____

Are you on any special diet, supplements, or have allergies?_____

_____

Mental Disorders: Anxiety____ Depression____ Schizophrenia____ Other_____

Any suicide attempts_____ To what degree are you feeling suicidal presently _____
(1 being low & 10 being high)

Emergency Contact

Name: _____ Relationship: _____

Phone numbers: Home_____ Cell_____ Work_____

I give permission for the above person to be contacted in the event of an emergency.

Client signature: _____ Date: _____