Selfcarematters Counselling

Intake Form

Personal Information:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONTACT NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Message: Y N

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AGE: \_\_\_\_\_\_\_\_\_\_GENDER:\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT & RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear of Selfcarematters Counselling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you previously received any type of mental health services (counselling, psychotherapy, psychiatric serves, etc.)?

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What brought you to counselling today? (briefly):

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What are you hoping to get out of counselling?

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Current Medication:

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Do you have any medical challenges?:

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Family History: (do any of your family members suffer from emotional or psychiatric issues?)

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SYMPTOM CHECKLIST

On a scale of 0-4 (0= none or not applicable, 1= a little, 2=moderate, 3= a lot, 4=extreme) rate

how much you have experienced each symptom over the past two weeks.

1. Feeling sad, down or depressed 0 1 2 3 4

2. Avoiding certain people or places 0 1 2 3 4

3. Loss of interest in activities I normally enjoy 0 1 2 3 4

4. Low energy/ feeling tired 0 1 2 3 4

5. Sleeping problems (insomnia, not staying asleep, early waking)

0 1 2 3 4

6. Not able to think clearly 0 1 2 3 4

7. Anxiety attacks 0 1 2 3 4

8. Worrying about things 0 1 2 3 4

9. Angry outbursts 0 1 2 3 4

10. Low self-esteem or low self-confidence 0 1 2 3 4

11. Feeling guilty 0 1 2 3 4

12. Feeling too stressed 0 1 2 3 4

13. Problems with relationship(s) 0 1 2 3 4

14. Thoughts of suicide 0 1 2 3 4

15. Drinking too much or abusing drugs 0 1 2 3 4

16. Other significant symptoms: 0 1 2 3 4

Anything else you would want us to know?

Preferred day and time for Counselling?

Preferred Counselling Format: Video Telephone