



New Client Intake Form

1 PERSONAL INFORMATION

First name:	Last name:
Age:	Date of birth:
Ethnicity:	Religion:
Marital status:	Number of children and their ages:
Sex/gender:	

Home address & Telephone:

Who do you live with & who supports you?

2 EMPLOYMENT INFORMATION

Are you currently working? Full time/ part-time/ Sick leave/ NA?



3 REASON FOR CHOOSING THERAPY/ME

How did you find out about me?

4 REASONS FOR SEEKING HELP

What are the reasons for your visit today?

How intense is your emotional distress? (Where 0 is not at all and 10 is incapacitating.)

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To what degree do your problems affect your ability to perform at work, at home, and in your relationships with others? (Where 0 is not at all and 10 is incapacitating.)

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When did these problems begin, and what was happening in your life at that time?



5 PSYCHIATRIC AND MEDICAL HISTORY

Have you been diagnosed with any psychiatric or mental health problems?

Have you been diagnosed with any physical health problems?

Are you on any medication, and what for?

Please provide the name of your family doctor and their contact details:



Please provide the name of your psychiatrist (if you have one) and contact details:

6 COUNSELING GOALS

What motivated you to come here today & what are your counseling goals?

Is there anything else that you would like to mention?