HARMONY COUNSELLING SERVICES

CLIENT INTAKE FORM

PRIVATE AND CONFIDENTIAL

Name: _____

Date of Birth: _____ **(DD /MM / YYYY)** Age: _____

Sexual Orientation: _____ Gender: _____

Nationality / Ethnicity: _____

Address: _____

City/Town: _____ Postal Code: _____ Prov.: _____

Cell phone: _____ Home phone: _____

Work phone: _____ Email: _____

Best form of communication preferred: Home phone ☐ Cell phone ☐ Email ☐

May we leave a message on your: Home phone ☐ Cell phone ☐ Email ☐

Highest education level completed: _____ Occupation: _____

Employment Situation

Unemployed ☐ Employed ☐ Self Employed ☐ Retired ☐

Employer: _____

Marital / Relationship Status

In Relationship ☐ Engaged ☐ Single ☐ Married ☐

Separated ☐ Divorced ☐ Common law ☐ Widowed ☐

Do you have children: Yes ◯ No ◯ If yes, how many: _____ Male _____ Female

Name of spouse/partner: _____ Age: _____

Years together: _____ Years married: _____ Nationality / Ethnicity: _____

Were you or your spouse/partner previously married/engaged? Yes ◯ No ◯

Years married/engaged: Yours: _____ Your Partner's: _____

Highest education level completed: _____

Employment Situation

Unemployed ☐ Employed ☐ Self Employed ☐ Retired ☐

Employer: _____

Referral Source (How did you find us)

Friend ☐ Family member ☐ Family doctor ☐ Lawyer ☐ HCS Website ☐

PsychologyToday Online: _____

Family / Household

Current living situation: _____

(People in Household)

	Name	***Relationship to you***	***Age***
1.			
2.			
3.			
4.			
5.			

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

Family of Origin (Are your parents still living)

Mother: Yes ◯ No ◯ Age: ____

If deceased, age at her death: _____ Known cause of death _____

Father: Yes ◯ No ◯ Age ____

If deceased, age at his death: _____ Known cause of death _____

Number of brothers/sisters: _____ Your birth order (e.g. oldest): _____

Significant Personal Information

Have there been any significant events or losses in your life? Yes ◯ No ◯

If yes, please specify…

Are you currently experiencing any of the following…

Eating disorder		Marital or Relationship difficulties	
Sleeping disorder		Parenting stresses	
Sexual dysfunction		Financial concerns	
Substance abuse - alcohol		Depression	
- drugs		Grief/Bereavement	

- prescription drugs		Anger	
- tobacco		Anxiety	
- other		Low Self Esteem	
Health (please list)		Trauma	
		PMS	
		Other:	

TREATMENT HISTORY

Do you have a Family Doctor? Yes ◯ No ◯

Doctor's Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

Are you presently taking prescribed medication? Yes ◯ No ◯

Name of medication (.e.g. Tylenol)	For the treatment of (.e.g. headaches)

How would you describe your situation/concern and how have you dealt with it in the past?

Have you had previous counselling/psychotherapy treatment? Yes ◯ No ◯

If yes, previous therapist's name: _____

What was the focus of treatment: _____

Duration of treatment: _____ Date of last visit: _____

Have you had one or more psychological assessments/tests in the past? Yes ◯ No ◯

Assessment was facilitated by: _____

What was the assessment or test for: _____

Please describe your previous counselling/psychotherapy experience.

What are your goals/expectations for counselling?

Spiritual Information

What is your faith/religion? _____

How would you describe your faith / religious practice or experience?

Are you open to developing your spirituality? Yes ◯ No ◯

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate or extended) experienced difficulties with the following? (Tick all that apply and list family members, e.g. sibling, parent, uncle, etc.)

Difficulty	**Relationship**		
Alcohol/substance abuse		Yes ◯	No ◯
Anxiety disorder		Yes ◯	No ◯
Bipolar disorder		Yes ◯	No ◯
Borderline personality disorder		Yes ◯	No ◯
Chronic illness		Yes ◯	No ◯
Depression		Yes ◯	No ◯
Eating disorders		Yes ◯	No ◯
Learning disabilities		Yes ◯	No ◯
Panic attacks		Yes ◯	No ◯
Schizophrenia		Yes ◯	No ◯
Suicide attempts		Yes ◯	No ◯
Trauma history		Yes ◯	No ◯
		Yes ◯	No ◯
		Yes ◯	No ◯