CLIENT Intake form

Today's Date: ________________ Name:____
Birthdate: ___________________________ Age:_______ Gender: M F prefer not to identify
Address: ____
Postal Code ___________________ Email ____
Address:____
Telephone: (H)_______________________(C)_______________________(W) ________________________

Ok to Leave Voicemail? YES NO Any specific directions?: ____

Presently living with:
____

How did you hear about Revive?:
____

Emergency Contact: ____Phone: ___________________________

Current Situation: Briefly describe the issue that prompted you to seek counselling at this time:
____
____
____
____

Have there been times when this issue got better or disappeared? Yes _____No ______ If yes, when?
____

What do you think helped?
____
____

Were there times when this issue was especially bad?
____
____

Are there other people who play a major role in causing problems or in helping you cope with problems?
Yes_____ No_____ Explain:
____
____

List three goals you hope to reach through counselling.
1.____
2.____
3.____

Is there anything else that you believe might be important for your counsellor to know at this time?
____
____

Counselling History:
Have you had previous counselling/therapy? Yes ________ No________ If yes, when?_____ For how long? _______ For what condition: ___________________________________ With Whom? (Name/ City) ____
Have you ever been hospitalized for a psychiatric condition? Yes_____ No______ If yes, please describe briefly:
____

What are your current supports and resources?
____
____

Marital/ Family Status (Check One): Single _______ Married ______ Separated ______ Divorced ______ Widowed _________
Dissatisfied Extremely Satisfied Relationship Satisfaction: 1 2 3 4 5 6 7
Spouse's Name: ___________________________ How long have you been married? _________________
Previous marriages? ________________________ When/ for how long? ___________________________
Reason for divorce?
____

Children's Names: Ages: Quality of Relationship: _________________________________
________________ _________________________________ _________________________________
________________ _________________________________ _________________________________
________________ _________________________________ _________________________________

Family Background:

Father's Name: _______________________________________ Age_____ Living ______
Deceased _____ If deceased, how and when?
____
Occupation ______________________________________ Any medical, psychiatric or substance abuse problems that you know of? ____
Quality of relationship currently?
____
Quality of relationship during childhood? ____

Mother's Name: _______________________________________ Age_____ Living _____
Deceased _____ If deceased, how and when?
____
Occupation ______________________________________ Any medical, psychiatric or substance abuse problems that you know of? ____________________________ __________________________________
Quality of relationship currently?
____
Quality of relationship during childhood? ____

Parents were: Married (how long?) ______ Divorced (how old were you?) _______ Not Married _________ Relationship with stepparents if applicable?
____
Sibling's Names: Ages: Quality of Relationship: _________________________________
________________ _________________________________ _________________________________
________________ _________________________________ _________________________________

Other noteworthy childhood relationships? Explain:

____
____

Significant childhood events (divorce, deaths, abuse, sickness, traumas, moving etc.)

____
____
____
____

Education and work life:

Years of education completed: ____
Degree/s received: ____
Specialized training or trade school:____

Do you have any learning or developmental disabilities? Please specify:

____

Do you have any background/experiences in the military or on a police force? ________ Describe briefly

____
____

Occupation: Primary place of work: ___________________________ Position: ______________________
How long have you worked there? ____________
Describe the nature of your work:

____
____

Do you find this work satisfying?

____

Number of hours work per week:

Medical History:

Describe any physical problems that require medication or physical care:

____
____
_ ____

Are you currently receiving medical treatment? Yes _____ No ______
When did you last consult your primary care physician?

____

Who is your primary care physician? (Name and contact information)

____

Other physicians whose care you regularly receive: ________________________________

____

Are you currently taking any prescription medication? Yes______ No_______ 5: Please list your medications:

Name	Dosage	Condition