Eugenia Lehmann
COUNSELLING SERVICES

Client Intake Form

Please provide the following information and bring to your first session. The information you provide here is protected as private and confidential information.

INDIVIDUAL INFORMATION Gender: □ Male □ Female

Full Name: _____ Birth Date: _____ Age: _____

Name of parent/guardian (if under 18 years): _____

Complete Address: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____ May we email you? □ Yes □ No

*Please note: All attempts to maintain the client's confidentiality and privacy have been put in place however web and email correspondence is not considered to be a confidential medium of communication.

Education Level (ie. High school, University, College): _____

Occupation/Profession: _____ How long? _____

Spiritual Upbringing: _____ Present Practice:_____

Is this important to you? □ Yes □ No

FAMILY

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

# of marriages: _____ Are you currently in a relationship? □ Yes □ No

If yes, how long? _____ Partner's name _____

Partner's Education level: _____ Occupation/profession: _____

Please list any dependents, relationship and ages (ie. Children, elders, friends)

_____

_____

Please list any other family supports and/or concerns and their relationship to you:

_____

_____

_____

GENERAL PHYSICAL AND MENTAL HEALTH QUESTIONS

Family Health Practitioner: _____

Can I send him/her an initial assessment letter? □ Yes □ No

If yes, to what address? _____

Medical Conditions: (circle all that apply)

Sleep Issues	Weight issues	Stomach	Heart issues	Headaches
Eating issues	Shortness of Breath	Blood Pressure	Headaches	Diabetes
Chronic Pain	Panic Attacks	Anxiety	Phobias	Grief	Depression

Other: _____

Are you currently taking any other prescription medication? □ Yes □ No

Please list all medications, dosages and timelines/dates:

_____

_____

_____

How many times per week do you generally exercise? _____ What types of exercise to you participate in? _____

Is alcohol consumption (your own or others) a part of your life? □ No □ Yes Do you feel it has an impact on your life? □ No □ Yes

Is recreational drug use (your own or others) a part of your life? □ No □ Yes Do you feel it has an impact on your life? □ No □ Yes

What significant life changes or stressful events have you experienced recently?

_____

_____

CLIENTS MENTAL HEALTH HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes

If yes, previous therapist/practitioner: _____

Past Mental Health Diagnoses: _____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list medication, dosages and timelines/dates:

_____

_____

_____

Suicidality or self-harm (past or present): □ No □ Yes If yes, please indicate timelines:

_____

Where you are now? □ None □ Thoughts □ Plan □ Means □ Attempts

Hospitalization (list reason): _____ timelines: _____

FAMILY HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	Relationship
Alcohol/Substance Abuse	Yes/No	
Anxiety	Yes/No	
Depression	Yes/No	
Domestic Violence	Yes/No	
Eating Disorders	Yes/No	
Obesity	Yes/No	
Obsessive Compulsive Behavior	Yes/No	
Schizophrenia	Yes/No	
Suicide Attempts	Yes/No	
Abuse (physical, emotional, sexual, verbal)	Yes/No	

ADDITIONAL INFORMATION

Previous Mental Health supports: _____

Outcomes: _____

Reason for discontinuing support: _____

Reason for seeking present counselling supports:

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

_____

Is there any additional information you feel would be relevant to this process?

_____

_____

_____

How did you hear about us? Who referred you? _____