Client Counselling Intake Form

Personal Information

NAME: _____

ADDRESS:_____

Postal Code: _____

CONTACT NUMBER: _____Message: Y N

EMAIL: _____

DOB: _____AGE: _____GENDER:_____

MARITAL STATUS: _____

OCCUPATION: _____

CHILDREN: _____

EMERGENCY CONTACT & RELATIONSHIP: _____

PHONE NUMBER: _____

How did you hear of **Self Matters Counselling**? _____

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

_____

_____

What brought you to counselling today? (briefly):

_____

_____

_____

_____

Client Counselling Intake Form

What are you hoping to get out of counselling?

_____

_____

Current Medication:

_____

_____

Do you have any medical challenges?:

_____

_____

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

_____

_____

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