New Client Intake Questionnaire

The purpose of this questionnaire is to gather information to tailor services to your needs and better serve you. Completing this questionnaire to the best of your ability, as fully and accurately as possible, will facilitate the development of your therapeutic program.

Please note that all information gathered in this questionnaire is in accordance with the confidentiality policy detailed in the previously signed consent form; and is therefore confidential.

Date : _____

General Information

Given name _____

Surname _____

Date of Birth _____

_____

Address _____

_____

Gender _____

Occupation _____

Education _____

Phone numbers:

Home _____ Messages accepted Yes No

Cell _____ Messages accepted Yes No

Work _____ Messages accepted Yes No

If you have children:

Number of children _____

How old are they? _____

How many live with you? _____

Relationship status:

Relationship status _____

If you have a partner:

Since when have you been together? _____

Do you live together? Yes No If so, since when? _____

Age of partner _____

Partner's occupation _____

Medical Information

Family Physician's Name _____

Family Physician's Phone number _____

_____

Family Physician's Address _____

_____

_____

Please list any medical conditions _____

_____

_____

Please list all medication you are taking at this time (prescription and non-prescription), including dose and frequency

Medication	Dose	Frequency

Do you use recreational drugs? Yes No

If you consume recreational drugs please list them, including frequency

Recreational drug	Frequency

Do you consume alcohol? Yes No If so, how frequently? _____

Clinical Information

What are your motives for consulting or the nature of your concerns?

_____

_____

_____

_____

_____

_____

_____

How long has this issue been persisting? _____

Please give a brief account of the history and progression of this issue

_____
_____
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_____
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What have you found helpful in coping with this issue?

Are you currently or have you received therapy/counselling in the past? Yes No

If so, please provide the name of clinicians, the period and motive of consultation

Name	Period	Motive

Have you ever been hospitalised for psychological difficulties? Yes No

If you have been hospitalised for psychological difficulties, please list dates, duration and nature of psychological difficulty at the time of hospitalisation

Date	Duration	Psychological difficulty

Have you experienced any of the following?

Physical abuse	Yes	No	Emotional abuse	Yes	No	Sexual abuse	Yes	No
Psychological abuse	Yes	No	Neglect	Yes	No	Family Violence	Yes	No
Witnessing a criminal act	Yes	No	Criminal act	Yes	No	Parental substance abuse	Yes	No
Parental illness	Yes	No	Parental psychological issues	Yes	No	Loss of a loved one	Yes	No
Familial uprooting	Yes	No	Children's Aid/Child Protection	Yes	No	Bullying	Yes	No

Social Network Information

Do you have anyone with whom you can share personal difficulties Yes No

Do you belong to any groups, organisations or clubs? Yes No

Do you do any sports or physical activities? Yes No

If you do sports of physical activities please list

_____

_____

_____

_____

_____

How do you spend your leisure time?

Expectations of Therapy

What prompted you to seek therapy/counselling? And what changes would you like to make?

What are your expectations and preferences for the therapeutic process as well as the therapist?