Whole Heart
COUNSELLING THERAPY

Client Intake

Please provide the following information for our records and for us to provide you the best possible care. Please answer to the best of your ability and comfortability.
Information on this form is completely confidential.

Personal & Contact Information

Full Name:_____

DOB / Age:_____

Full Address:_____

Home Phone #:_____ Ok to leave message: Yes or No

Cell Phone #:_____ OK to leave message: Yes or No

Alternate Phone #:_____ Ok to leave message: Yes or No

Email Address (that can be used for communication between you & your therapist):

_____

You will receive an appointment reminder 24-48 hours prior to the session. Please circle one option:

via Email via Text message

Marital Status (# of years):

Single ___ Common Law ___ Engaged___ Married ___ Separated ___ Divorced ___ Widowed ___

Children, if any: Names(s) & Age(s)

_____

How did you hear about Whole Heart Counselling Therapy? _____

Please describe your current reasons for seeking therapy:

_____

_____

_____

What are your hopes and goals for this therapy?

_____

_____

_____

Alana Buller, M.A., C.C.C., Counselling Therapist
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General Health

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health issues you are currently experiencing (including, but not limited to: sleep issues, headaches, stomach, heart issues, blood pressure, diabetes, weight issues, appetite, etc.):

_____

Hospitalization(s): Reason(s):_____ Date:_____

Mental Health:

Self: Any Diagnoses: _____ If yes, please specify: _____

Have you had suicidal or self-harm thoughts recently (past 6 months)?

Frequently Sometimes Rarely Never

In the past? Frequently Sometimes Rarely Never

If you answered frequently, sometimes or rarely to experiencing suicidal or self-harm thoughts recently, please name two people who can be contacted to help ensure your safety:

Name & Relationship to you:_____ Phone #_____

Name & Relationship to you:_____ Phone #_____

Family Member(s): Past Diagnoses: _____ If yes, please specify relationship & diagnosis:

_____

In the past year, have you experience any significant life changes or stressors (positive &/or negative):

_____

Have you previously sought assistance from a mental health professional? _____ If yes:

Name of Professional(s):_____Date(s):_____

Reason for seeking assistance:_____

Do you consider yourself religious? Yes or No? … **Spiritual?** Yes or No?

If yes, how would you describe your religion or spirituality?_____

Is this an important aspect of your life: Yes or No

By signing below, you agree that the information you provided in this form is correct and true:

Signature: _____ **Date:**_____

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