



MENTAL HEALTH - ADULT INTAKE

CONFIDENTIAL CLIENT INFORMATION

Our goal is to make the most of each appointment we have. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following information about yourself as completely and legibly as possible. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so. This information is confidential: demographic information will be seen by 360 Wellness administrative staff and all other information will only be seen by your psychologist.

Name: _____ Gender: () Male () Female

DOB: _____ Age: _____ Birthplace: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ may we leave a message? () Yes () No

Cell/other: _____ may we leave a message? () Yes () No

Email: _____ may we email you? () Yes () No

**please note that email is not considered to be a confidential medium of communication*

MARITAL STATUS:

() Married () Never Married () Domestic Partnership

() Separated () Divorced () Widowed

Partner/Spouse's Name: _____ Age: _____ Duration of Relationship: _____

Children's name(s) and age(s): _____

Person to alert in the case of an emergency: _____

Relationship to you: _____ Phone: _____

How did you come to choose me as your therapist? () website () school () psychology today

() friend/coworker () corporate program () social media () google search () other

Using the following scale, how would you rate the following?

1 - poor 2 - unsatisfactory 3 - satisfactory 4 - good 5 - very good

() Physical health () Sleep () Eating habits () Home life

() Sexual health () Spiritual health () Emotional/Mental health () Leisure

() Romantic life () Family life () Work situation () Friendships

() Financial situation () School functioning () Physical health



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Please describe the concerns that have brought you here.

Please describe how you handle stressors and cope with the concerns you have described above.

Please identify past or present thoughts of wanting to hurt yourself or someone else.

Please identify the name of any clinician(s) you have seen in the past (psychiatrist, psychologist, counsellor, etc.), the months you saw them (e.g., Nov 14 - Feb 15), and the nature of the difficulty at the time.

Please list any diagnoses, medical or otherwise.

Please list any medications you are taking, including prescription and over-the-counter medications, as well as frequency and dose.

Please describe any significant current or past medical problems you have faced.

Please describe what you hope to be able to do or achieve as a result of therapy.

Please describe some of your weaknesses.

Please describe some of your strengths.
