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The information requested below is very important to understanding your life experiences and critical to identifying treatment goals and interventions. Please answer each item as thoroughly as possible or enter N/A if not applicable. Please type your responses into the grey boxes.

# ADULT INTAKE FORM

YOUR FULL NAME       DATE OF BIRTH

BIRTHPLACE       DATE FORM COMPLETED:      

HOW YOU LEARNED OF OUR SERVICES:

## CONTACT INFORMATION

HOME PHONE     -     -      CELL PHONE     -     -        
  
WORK PHONE     -     -      EMAIL ADDRESS

MAILING ADDRESS: Address Line 1   
 Address Line 2  
 City, Province Postal Code

WHAT IS THE BEST WAY FOR US TO CONTACT YOU?

LIST ALL MEMBERS OF YOUR IMMEDIATE FAMILY:

|  |  |  |  |
| --- | --- | --- | --- |
| NAME | AGE | RELATIONSHIP | GRADE /  OCCUPATION |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

## RELATIONSHIP HISTORY

(Describe significant past and current partner relationships)

Please enter information here

## CURRENT PRESENTING CONCERNS

(Describe any psychological, emotional, relationship or behavioral concerns + note when you began to experience these difficulties)  
Please enter information here

WHAT HAS HELPED WITH THESE DIFFICULTIES THUS FAR?

Please enter information here

DEVELOPMENTAL OR MENTAL HEALTH DIAGNOSIS

(List any diagnosis of psychiatric and/or developmental disabilities + how impacts your functioning)

Please enter information here

DESCRIBE ANY PAST EXPERIENCES OF CHILD MALTREATMENT (physical, emotional, sexual, neglect)  
Please enter information here

DESCRIBE ANY HISTORICAL OR CURRENT TRAUMAS YOU HAVE EXPERIENCED

Please enter information here

## STRENGTHS AND AREAS OF RESILIENCY

PLEASE DESCRIBE YOUR INTERESTS (i.e sports, hobbies,)

Please enter information here

DESCRIBE YOUR STRENGTHS + PERSONAL QUALITIES

(intuition, creativity, intelligence, humor, supports, etc)

Please enter information here

DESCRIBE YOUR CURRENT SOCIAL SUPPORTS

(Friends, teachers, coaches, pets, extended family members, past counselors, etc)

Please enter information here

IDENTIFY GOALS YOU WOULD LIKE TO ACHIEVE THROUGH THERAPY  
Please enter information here

## MEDICAL INFORMATION

NAME OF PRIMARY CARE PHYSICIAN:

PHONE#     -     -      FAX # (If available)     -     -

LIST ANY PRESCRIBED OR NATURALPATHIC MEDICATIONS YOU ARE NOW TAKING:

Please enter information here

LIST ANY SIGNIFICANT HISTORICAL OR CURRENT HEALTH PROBLEMS

Please enter information here

DESCRIBE ANY PAST THERAPY YOU HAVE ATTENDED:

Please enter information here

LIST ANY OTHER AGENCIES INVOLVED WITH YOU OR YOUR FAMILY

Please enter information here

PLEASE DESCRIBE YOUR GOALS AND HOPES FOR THERAPY

Please enter information here

DESCRIBE ANY ADDITIONAL INFORMATION RELEVANT TO YOUR PARTICIPATION IN THERAPY

Please enter information here

LIST ANY CONCERNS OR QUESTIONS REGARDING YOUR THERAPY

Please enter information here

Thank you for your time spent in completing this detailed intake form