Client Intake Form Conexus Counselling

Personal Information							
Full Name:		_ DOB:	Age:				
Address:		Postal Code:					
Home Phone:		s 🗖 No Message	OK?				
Work/Alternative #:		s 🛛 No Message	OK?				
Email Address: (optional)_		(Please print clea	rly)				
Occupation/Profession:		How long?					
If presently unemployed,	describe the situation:						
Education Level: INone IGrades 1-4	Grades 5-8 Grades 8-12	D Post Seconda	ary				
Religious upbringing:	Present Affiliat	tion:					
Is this an important part of	of your life? Y/N						
Marital Status:	# of marriages: Spous	e's name:					
Living with a partner? Y/	N How long: Partne	er's name:					
Education level of spouse None Grades 1-4	∕partner: □ Grades 5-8 □ Grades 8-12	D Post Seconda	ary				
Your children:	Dependents in home (children, elders, pets, etc.) (complete on back if required)						
	Name	Relationship	DOB (mm/dd/yy)				
#1 M F Age:							
#2 M F Age: #3 M F Age:							
#3 M F Age: #4 M F Age:							
Family Information	How long there?	_Ethnic identificatio	n:				
Your siblings:	Father alive? Y/N Where resid	incu					
#1 M F Age:	ramer anve: 171N where resid	g					
#1 M F Age:	Profession:	Relationship: —					
#3 M F Age:		Poo	or Excellent				
#4 M F Age:	Mother alive? Y/N Where resid	ling					
#5 M F Age:							
#6 M F Age:	Profession:	Relationship:	or Excellent				
Parents divorced?	If yes, what year?	Your age a	t the time:				
If deceased, what year?	Your age at the time:	Cause of d	eath:				

General Medical Condition

Family Physician:				Phone #:				
Emergency Contact:			Phone #:					
Medical Conditions (circle all that apply	y):						
Sleep issues Headac	thes Stomach	Heart	Issues	Blood Pressure	Thyroid	Diabetes		
Weight Issues Appet	te Shortness	of Breath	Otl	ner:				
Hospitalization (espec	ially head injury):							
Reason(s): Dates: from/ to						/		
Mental Health Histor Self: Past Diagnoses (spec	•		(D					
Suicidality or self harm:		□ Mean						
Family Member(s): (specify) Past Diagnoses (specify) (Depression, Schizophrenia, OCD, etc.)								
Medication/Dosage (additional on back of page)	Year/Month 1s	st Given	Side F	Effects/Result	Reason			
History of abuse (physical, mental, emotional, sexual): 🗆 Yes 🛛 🗖 No								
Alcohol use: \Box never \Box rarely \Box regularly \Box frequently \Box excessive								
Non-medicinal drug use: \Box never \Box rarely \Box regularly \Box frequently								
Previous Professiona	l Mental Health	n Assistaı	nce					
Name of professional: Dates (mm/yy):								
Reason for service:								
Outcome:								
Reason for Present S	<u>ervice</u>							
Reason for counseling: _								
What I would like to cha								