**Client Intake Form**
**Conexus Counselling**

**Personal Information** ☐ Male ☐ Female

Full Name: _____ DOB:_____ Age: _____

Address:_____ Postal Code: _____

Home Phone: _____ ☐ Yes ☐ No **Message OK?**

Work/Alternative #: _____ ☐ Yes ☐ No **Message OK?**

Email Address: (optional)_____ (Please print clearly)

*Emergency Contact:* _____ Phone #: _____

Occupation/Profession: _____ How long? _____

If presently unemployed, describe the situation: _____

_____

Education Level:
☐ None ☐ Grades 1-4 ☐ Grades 5-8 ☐ Grades 8-12 ☐ Post Secondary _____

Religious upbringing: _____ Present Affiliation: _____
Is this an important part of your life? Y/N

Marital Status: _____ # of marriages: _____ Spouse's name: _____

Living with a partner? Y/N How long: _____ Partner's name: _____

Education level of spouse/partner:
☐ None ☐ Grades 1-4 ☐ Grades 5-8 ☐ Grades 8-12 ☐ Post Secondary _____

| **Your children:** |
|---|
| |
| #1 M F Age: |
| #2 M F Age: |
| #3 M F Age: |
| #4 M F Age: |

| **Dependents in home (children, elders, pets, etc.) (complete on back if required)** | | |
|---|---|---|
| **Name** | **Relationship** | **DOB (mm/dd/yy)** |
| | | |
| | | |
| | | |
| | | |

**Family Information**

Where were you born? _____ How long there? _____ Ethnic identification: _____

| **Your siblings:** |
|---|
| #1 M F Age: |
| #2 M F Age: |
| #3 M F Age: |
| #4 M F Age: |
| #5 M F Age: |
| #6 M F Age: |

Father alive? Y/N Where residing: _____

Profession: _____ Relationship: _____
Poor Excellent

Mother alive? Y/N Where residing: _____

Profession: _____ Relationship: _____
Poor Excellent

Parents divorced? _____ If yes, what year? _____ Your age at the time: _____

If deceased, what year? _____ Your age at the time: _____ Cause of death: _____

## General Medical Condition

**Family Physician:** _____ Phone #:_____

**Emergency Contact:** _____ Phone #: _____

**Medical Conditions** (circle all that apply):

Sleep issues  Headaches  Stomach  Heart Issues  Blood Pressure  Thyroid  Diabetes

Weight Issues  Appetite  Shortness of Breath  Other: _____

**Hospitalization** (especially head injury):

Reason(s): _____  Dates: from ____/____ to ____/____
month/year  month/year

**Mental Health History:**

Self: Past Diagnoses (specify) _____ (Depression, Schizophrenia, OCD, etc.)

Suicidality or self harm:
☐ None  ☐ Thoughts  ☐ Plan  ☐ Means

Family Member(s): (specify) _____

Past Diagnoses (specify) _____ (Depression, Schizophrenia, OCD, etc.)

Suicide: ☐ Attempt  ☐ Completion (specify) _____

| Medication/Dosage (additional on back of page) | Year/Month 1st Given | Side Effects/Result | Reason |
|---|---|---|---|
| | | | |
| | | | |

History of abuse (physical, mental, emotional, sexual): ☐ Yes  ☐ No

Alcohol use: ☐ never  ☐ rarely  ☐ regularly  ☐ frequently  ☐ excessive

Non-medicinal drug use: ☐ never  ☐ rarely  ☐ regularly  ☐ frequently

## Previous Professional Mental Health Assistance

Name of professional: _____ Dates (mm/yy): _____

Reason for service: _____

Outcome: _____

## Reason for Present Service

Reason for counseling: _____

_____

What I would like to change/Issues I want to address: _____

_____