## Client Intake Form Bergen & Associates Counselling

Personal Information	☐ Male	☐ Female		
Full Name:			DOB:	Age:
Address:			Postal Code:	
Home Phone: □ Yes			□ No Message OK?	
Work/Alternative #: \Bigcup Yes			□ No Message OK?	
Email Address: (optional)				
Occupation/Profession:			How long?	
If presently unemployed,	describe the situation	:		
Education Level:  □ None □ Grades 1-4	4 □ Grades 5-8	☐ Grades 8-12	□ Post Second	ary
Religious upbringing:		Present Affiliation	on:	
Is this an important part of				
	,			
Marital Status:# of marriages: Spouse's name:				
Living with a partner? Y/	N How long:	Partner	r's name:	
	☐ Grades 5-8	☐ Grades 8-12		ary
Your children:	Dependents in home (children, elders, )  Name		pets, etc.) (complete Relationship	on back if required)  DOB (mm/dd/yy)
#1 M F Age:	Nan	ie	Kelationship	DOB (mm/dd/yy)
#2 M F Age:				
#3 M F Age: #4 M F Age:				
#4 M F Age:				
Family Information				
Where were you born?	How long	g there?	Ethnic identification	n:
Your siblings:	Father alive? Y	/N Where residing	ng:	
#1 M F Age:			Relationship: Excellent	
#2 M F Age:	Profession:		Relationship: —	or Excellent
#3 M F Age:				
#4 M F Age: #5 M F Age:	Mother alive?	Y/N Where residi	ng:	
#6 M F Age:			Relationship: —	
			Poo	or Excellent
Parents divorced?	If yes, wh	at year?	Your age at the time:	
If deceased, what year?	Your age	at the time:	Cause of death:	

## **General Medical Condition** Family Physician: Phone #: **Medical Conditions** (circle all that apply): Heart Issues Sleep issues Headaches Stomach Blood Pressure Thyroid Diabetes Weight Issues Appetite Shortness of Breath Other: **Hospitalization** (especially head injury): Dates: from // to // month/year **Mental Health History:** Self: Past Diagnoses (specify) \_\_\_\_\_\_ (Depression, Schizophrenia, OCD, etc.) Suicidality or self harm: □ Plan □ None ☐ Thoughts ☐ Means Family Member(s): (specify) Past Diagnoses (specify) \_\_\_\_\_ (Depression, Schizophrenia, OCD, etc.) Suicide: ☐ Attempt ☐ Completion (specify) Medication/Dosage Year/Month 1st Given Side Effects/Result Reason (additional on back of page) History of abuse (physical, mental, emotional, sexual): ☐ Yes $\square$ No □ excessive Alcohol use: □ never □ rarely □ regularly ☐ frequently 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: