Client Intake Form Conexus Counselling

In the event that a field does not provide adequate space, please provide additional details in the space provided at the end of this form.

Personal Information				
Full Name:		_ DOB:	Age:	
Address:		_ Postal Code:		
Home Phone: \square Ye		□ No Message OK?		
Work/Alternative #:	□ Ye	□ No Message OK?		
Email Address: (optional)				
Occupation/Profession:		How long?		
If presently unemployed, de	escribe the situation:			
Education Level: □ None □ Grades 1-4	☐ Grades 5-8 ☐ Grades 8-12	□ Post Second	ary	
Religious upbringing:	Present Affilia	tion:		
Is this an important part of	your life? Y/N			
Marital Status:	arital Status: # of marriages: Spouse's name:			
Living with a partner? V/N	How long: Partn	er's name:		
Education level of spouse/p None Grades 1-4 Your children:	Dependents in home (c		•	
Gender	Name	Relationship	DOB (mm/dd/yy)	
#1 Age: #2 Age: #3 Age: #4 Age:				
Family Information	How long there?	Ed.: 'l .'C .'		
where were you born?				
Your siblings:	Father alive? Where resid	ding:		
#1 Age:	Profession:	Relationship:		
#2 Age:				
#3 Age: #4 Age:				
#4 Age: #5 Age:	Mother alive? Y/N Where residing:			
#6 Age:	Profession:	Relationship:	_ Relationship:	
Parents divorced?	If yes, what year?	Your age	Your age at the time:	
If deceased, what year?	Your age at the time: Cause of death:		death:	

General Medical Condition Family Physician: Phone #: Emergency Contact: _____ Phone #: _____ **Medical Conditions** (select 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): ____ 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 Year/Month 1st Given Side Effects/Result Reason History of abuse (physical, mental, emotional, sexual): ☐ Yes \square No □ regularly Alcohol use: □ never □ rarely ☐ frequently □ excessive □ regularly □ frequently Non-medicinal drug use: □ never □ rarely Previous Professional Mental Health Assistance Name of professional: _____ Dates (mm/yy): ____ Reason for service: Outcome:

Additional Information