Conexus Counselling Client Intake Form

Personal Information

Full Name: ______________________ DOB: __________ Gender: __________ Age: ______

Address: ______________________________ Postal Code: __________

Home Phone: ______________________________ Yes No Message OK?

Work/Alternative #: ______________________________ Yes No Message OK?

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

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?

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:	
Age:	Gender:
Age:	Gender:
Age:	Gender:
Age:	Gender:

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:	
Age:	Gender:
Age:	Gender:
Age:	Gender:
Age:	Gender:
Age:	Gender:
Age:	Gender:

Father/Caregiver alive? Where residing? ______________________

Profession: ______________________ Relationship: ______________________ (Poor — Excellent)

Mother/Caregiver alive? 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 counselling: ____

____

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

____