Adult Intake Forms

IDENTIFYING INFORMATION

Name: _____ Date: _____ Date of birth:_____

Street Address: _____

City:_____ Province:_____ Postal Code:_____

Home phone: _____ Cell phone: _____ Work phone: _____

Best number to contact? _____ Can we leave a voicemail? _____

Best email address to reach you: _____

Can we contact you by email to let you know about groups or other updates about the clinic? Yes ☐ No ☐

Highest level of education: _____ Occupation: _____

Employer: _____ Hours worked per week: _____

Race/Ethnicity: _____ Religious Affiliation: _____

Marital Status (Select): Single ☐ With Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐

How did you hear of Dr. Jennie Psychology Group? _____

Do you have extended Health Care Insurance? Yes No Insurance company name _____

Emergency contact name: _____ Relationship _____

City: _____ Phone number: _____

What type of therapy are you interested in?

Individual Adult Therapy ☐ Couples Therapy ☐ Parent Consults ☐

SPOUSE INFORMATION

Name of spouse/partner: _____

Occupation of spouse/partner: _____

My relationship is (Circle One):

Very Happy ☐ Happy ☐ Average ☐ Unhappy ☐ Very Unhappy ☐

How would you describe your relationship with your partner?

_____

_____

_____

_____

FAMILY INFORMATION

Did either of your parents have issues with drugs, alcohol, or other?

_____

_____

_____

_____

Describe your life as a teenager:

_____

_____

_____

_____

REASONS FOR SEEKING TREATMENT

Describe your life in the last 6 months:

Please briefly describe the problems you are currently experiencing:

What has happened to cause you to seek help NOW?

What are your goals for therapy? What do you hope to achieve with treatment?

What do you consider to be other stresses in your life?

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Red Deer, AB
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HISTORY OF PROBLEM

When did you first start experiencing the problem(s) that brought you to the office today?

_____

_____

How often does the problem occur? _____

How long does it last? _____

Do you have any thoughts of harming yourself? ☐ Yes ☐ No

Have you ever attempted to harm yourself? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

Do you have any thoughts of harming someone else? ☐ Yes ☐ No

Have you ever attempted to harm someone else? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

Have you experienced any trauma or abuse? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, when/where was this, and for what reasons?

_____

_____

_____

Have you had other previous therapy/counselling of any kind? ☐ Yes ☐ No

If yes, for how long?

_____

_____

What concerns were addressed in therapy?

_____

_____

Was this experience helpful (please explain)?

_____

_____

Do you currently do/take any of the follow?

Smoke? ☐ Yes ☐ No

If yes, how many packs per day/week? _____

Alcohol? ☐ Yes ☐ No

If yes, how much and how often? _____

Recreational drugs? ☐ Yes ☐ No

If yes, how much and how often? _____

Other? _____

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FAMILY HEALTH

Have any family members been diagnosed with any of the following? (Please check if YES):

☐ Cancer	☐ Mental Retardation
☐ Tourette's Syndrome	☐ Anxiety
☐ Diabetes	☐ Seizures/Epilepsy
☐ Heart Disease	☐ Reading Problems
☐ High Blood Pressure	☐ Speech/Language Problems
☐ Behaviour Disorder (i.e., ODD)	☐ Attention Deficit/Hyperactivity Disorder
☐ Depression	☐ Sleeping Difficulties
☐ Autism Spectrum Disorder	☐ Alcohol/Drug Abuse
☐ Schizophrenia	☐ Kidney Disease
☐ Bipolar Disorder	☐ Migraine Headaches
☐ Multiple Sclerosis	☐ Physical Disability
☐ Alzheimer's Disease	☐ Stroke
☐ Other Learning Problems	☐ Tics
☐ Other significant health or emotional problem:	

Have you been diagnosed with any of the following?

☐ Cancer	☐ Mental Retardation
☐ Tourette's Syndrome	☐ Anxiety
☐ Diabetes	☐ Seizures/Epilepsy
☐ Heart Disease	☐ Reading Problems
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☐ Bipolar Disorder	☐ Migraine Headaches
☐ Multiple Sclerosis	☐ Physical Disability
☐ Alzheimer's Disease	☐ Stroke
☐ Other Learning Problems	☐ Tics
☐ Other significant health or emotional problem:	

What kind of stressful events have family members experienced recently?

_____
_____
_____
_____
_____

What kinds of stressful events have you experienced recently?

_____
_____
_____
_____
_____

MEDICAL CARE AND HISTORY

Family Physician: _____ Clinic Name: _____

Clinic phone number: _____ How often do you see a doctor? _____

Date of last visit: _____

Naturopathic Doctor: _____

Have you been prescribed medications? Yes ☐ No ☐

Please list all current medications you are currently taking:

_____
_____
_____

Supplements:

_____
_____
_____

Do you have any history of the following?

Condition	Age	Treated by Whom?	Outcome of treatment
Serious Accidents			
Head injury			
Serious illness			
Eye, ear, nose, or throat problems			
Seizures			
Allergies			
Loss of consciousness			
Hospitalizations			
Other:			

EDUCATION

What is the highest level of education you have achieved so far? _____

What are your educational/career goals? _____

Describe any difficulties you are having achieving your goals:

_____

_____

_____

WORK

Are you currently working? Yes ☐ No ☐

If yes, how often?

_____

Are you satisfied with your current employment situation?

_____

_____

PARENTING

Children? _____ Number of Children: _____

Name: _____ Gender: _____ Age: _____ Living with you? _____

Name: _____ Gender: _____ Age: _____ Living with you? _____

Name: _____ Gender: _____ Age: _____ Living with you? _____

Name: _____ Gender: _____ Age: _____ Living with you? _____

Name: _____ Gender: _____ Age: _____ Living with you? _____

Describe your approach to parenting:

_____

_____

_____

What challenges do you experience parenting your child/children?

_____

_____

_____

What areas of your parenting do you want support with?

_____

_____

_____

Describe your relationship with your child/children:

_____

_____

_____

_____

FRIENDSHIPS

Do you have close friends to talk to? Are you happy with the friendships you have?

_____
_____
_____

INTERESTS AND ACTIVITIES

Please describe your strengths and positive characteristics:

_____
_____
_____
_____

What extracurricular activities (i.e., sports, music, clubs, religious organizations) do you participate in?

_____
_____
_____
_____

What hobbies or interests do you have?

_____
_____
_____
_____

Any other information you feel is important and was not asked about?

_____
_____
_____
_____

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