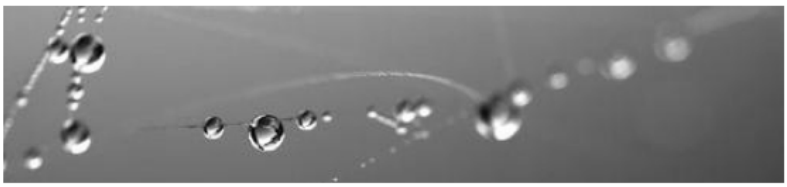
CORNISH & GILLETA
REGISTERED DOCTORAL PSYCHOLOGISTS



CLIENT INTAKE FORM

Please provide the following information. The information you provide here is protected as confidential information.
If you have accessed this form online, please bring a completed copy to your first session.

IDENTIFYING INFORMATION

Name: _____ Date: _____

Mailing Address: _____

City/Province: _____ Postal Code: _____

Home Phone: _____ May we leave a message? ☐ Yes ☐ No

Work Phone: _____ May we leave a message? ☐ Yes ☐ No

Cell Phone: _____ May we leave a message? ☐ Yes ☐ No

Email: _____ May we email you? ☐ Yes ☐ No
Please note: email correspondence is not considered to be a confidential medium of communication

Date of Birth: _____ Age: _____

Relationship Status (e.g., single, married, living with partner): _____

Children:	Names of Children	Age
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Education (years): _____ Degree/Diploma/Certificate/Designation: _____

Occupation/Work Emphasis: _____ Employer: _____

MEDICAL INFORMATION

Family Physician: _____

What physical health problems do you have? How are they being treated? To what extent are the treatments effective? _____

_____

_____

SUBSTANCE USE HISTORY

Substance	Current Amount	Current Frequency	Last Use	Duration of Use Across Lifetime
Alcohol	_____	_____	_____	_____
Prescription Drugs	_____	_____	_____	_____
Nonprescription Drugs	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

PRESENTING ISSUES AND CONCERNS

For what issues are you seeking treatment?

_____

_____

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

Previous Mental Health Treatment:

Type of Treatment	Date	Provider/Program	Reason for Treatment
Counselling	_____	_____	_____
Psychiatric Hospitalization	_____	_____	_____
Drug/Alcohol Treatment	_____	_____	_____

If you are currently taking psychotropic/psychiatric medication, please indicate the following:

Medication	Amount & Frequency	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever seriously considered or attempted suicide? If yes, when? _____

_____

Have you ever engaged in self-harming behaviours such as cutting or burning? If yes, when? _____

_____

Please indicate instances of trauma and/or overwhelming stress you have experienced (e.g., abuse, death of a loved one, chronic illness):

_____

_____

_____

Please indicate if there is a family history of any of the following and list the family member.

Mental Health Issues	Family Member
Alcohol Abuse or Dependence	_____
Drug Abuse	_____
Anxiety	_____
Depression	_____
Bipolar Depression	_____
Domestic Violence	_____
Eating Disorders	_____
Obsessive Compulsive Disorder	_____
Borderline Personality Disorder	_____
Schizophrenia	_____
Suicide Attempts	_____
Suicide	_____