**Client Intake Information**

Name: Preferred gender pronoun:

Date of Birth: Current Age:

Telephone: Alternative:

Can I leave a detailed message? Yes / No

Personal email address:

Home Address:

Who referred you or how did you find me (if online please specify which website)?

Occupation:

Any current physical health and/or mental health concerns/diagnosis:

Current Medications and Dosage (prescribed or over the counter):

Current vitamins or herbs taken:

Any Alternative treatments that you participate in (i.e. acupuncture, reiki etc:

On an average week how many: drinks do you have? \_\_\_\_\_\_ Cigarettes do you smoke? \_\_\_\_\_\_\_

On an average week how: often you smoke marijuana? \_\_\_\_\_\_ Often do you use recreational drugs? \_\_\_\_\_ Which ones?

Current Relationship Status: Current Partner’s name/s & age/s (if applicable):

Dependents name and age (if applicable):

Have you ever attended counselling in the past? YES NO

If so, what did you find the most helpful for you?

What did you not find helpful?

Top Three Goals for Therapy:

1)

2)

3)

Any additional information you think would be helpful before we start: