Leah Neumann, MSW, RSW

Client Intake Information

The information requested in this form is kept **strictly confidential** and helps me to assist you. Please take the time to fill out the form as completely as you can.

General Information

Last Name: _____ First Name: _____ Middle Initial: _____
Birth Date: ____/____/____ Age: ____ Ethnic origin/identity: _____
Street Address: _____ Apt # _____
City, Province, and Postal Code: _____
Home Telephone: _____ Okay to leave a message? ☐ Yes ☐ No
Business Telephone: _____ Okay to leave a message? ☐ Yes ☐ No
Cell: _____ Okay to leave a message? ☐ Yes ☐ No
Guardian / Parent (if under 18): _____
Emergency Contact: _____
Relation: _____ Telephone: _____
Who referred you here? If you were not referred, how did you find out about my practice? _____
Religious/denominational preference (if any): _____

Employment / Education Information

☐ Full-time employee ☐ Part-time employee ☐ Self-employed ☐ Unemployed
Place of employment: _____
Type of work you do: _____
Highest level of education completed: ☐ High School ☐ Some College ☐ College Degree ☐ Graduate Degree
☐ Professional Training ☐ Other: _____

Family Information

Relationships: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐ Cohabiting
Are your parents alive or deceased? If alive, how old are they? _____
Siblings: Number of *Brothers* _____ Number of *Sisters* _____ ☐ Only Child
List ages of *brothers* [_____] of *sisters* [_____]
Do you have any children? ☐ Yes ☐ No
If yes, what are their names and ages? _____
_____
_____
If yes, where do they reside? _____

Medical Information

Family doctor: _____
Other health care providers you are seeing:
Name: _____ Profession: _____
Name: _____ Profession: _____
Name: _____ Profession: _____
Have you ever been diagnosed with a mental illness? ☐ Yes ☐ No (continue on next page)

If yes, what was the diagnosis? _____

When were you diagnosed? _____

Are you currently taking any prescription medications? ☐ Yes ☐ No

If so, what are the names and dosages? _____

How much alcohol do you drink during a typical week? _____

Have you ever experienced any problems due to consuming alcohol or other mood-altering substances? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have any people in your life ever been concerned about your drinking or drug use? ☐ Yes ☐ No

If yes, please explain: _____

_____

Please indicate any serious conditions, illnesses, injuries, and/or hospitalizations you have experienced, with the approximate dates: _____

_____

_____

_____

_____

_____

Therapeutic/Counselling History and Goals

Have you ever had previous therapy/counselling? ☐ Yes ☐ No

If yes, when? _____

Reason? _____

What was helpful? _____

What was not helpful? _____

List the five most stressful events in your life:

1. _____
2. _____
3. _____
4. _____
5. _____

Do any of these feel unresolved? ☐ Yes ☐ No

Please explain: _____

_____

_____

What leads you to seek therapy/counselling at this time? _____

_____

_____

How long have these problems been an issue for you? _____

What would you like to accomplish in therapy/counselling? _____

_____

_____

What strengths, character traits, and abilities do you bring to therapy/counselling? _____

_____

_____

What is your present support network? (Please indicate specific names of friends, family members, community members)

_____

_____

_____

Please provide any other relevant information that is not covered in this questionnaire: _____

_____

_____

_____

_____

Acknowledgement

Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

_____ _____

Client's Signature Date