# Intake Form

**File ID:** ☐

**Date:** ____________________

Client Name: ______________________________________________________ DOB: _________________ Age:______

Parent/Guardian (if client is under age of 16): ____________________________________________________________

Street Address: _______________________________________________________ City: __________________________

Postal Code: _____________________ Email: ____________________________________________________________

Preferred contact#: _____________________________________________________ Circle: mobile / work / home

Alternate contact#: ______________________________________________________ Circle: mobile / work / home

## EMERGENCY CONTACT

Name: _______________________________________________________ DOB: _____________________ Age:______

Preferred contact#: _____________________________________________________ Circle: mobile / work / home

Alternate contact#: ______________________________________________________ Circle: mobile / work / home

**How did you hear about Meristem?** Theravive ☐ Psychology Today ☐ TherapyTribe ☐ Referral ☐
Word of Mouth ☐ Website ☐ Facebook ☐ Oakville Magazine ☐ Other: ___________________________

Reason for visit (briefly): ________________________________________________________________________________

______________________________________________________________________________________________________

Do you have extended health insurance? ______ If so, how many appts. are covered (approx.)? ______________

## MEDICAL HISTORY

General health: _______________________________________________________________________________________

Are you currently under a doctor's care? _______ If yes, state reason: _______________________________________

Name of family or other doctor: _________________________________________________________________________

Address & phone number: _______________________________________________________________________________

Current medications, if applicable: (indicate below name of medication, dosage and reason for taking)

________________________________________ / ___________ / _____________________________________________

________________________________________ / ___________ / _____________________________________________

________________________________________ / ___________ / _____________________________________________

Have you ever been hospitalized for a physical illness? _______ Describe: ________________________________

Have you ever been hospitalized for a mental illness? _______ Describe: _________________________________

Have you had a recent illness, injury or surgery? _______ Describe: _____________________________________

Do you have recurrent or chronic conditions? _______ Describe: ________________________________________

When was your last medical examination? _________________ Do you smoke? _____ For how long? _________

Do you drink alcohol? _______ If yes, what kind? ___________________________________________________

How often do you drink? Per day ______________________________ Per week _________________________

Do you take illicit drugs? ______ If yes, what kind? _____________________________ How often? ___________

Have you had any previous talk therapy/counselling? _______ If yes, describe when, for how long, and what for:

______________________________________________________________________________________________

______________________________________________________________________________________________

Was talk therapy/counselling helpful? ______________________________________________________________

**FAMILY HISTORY & INFORMATION**

**Your Marital Status:** Circle one: SINGLE MARRIED COMMON LAW SEPARATED DIVORCED WIDOWED

If currently married, how long? _____________ Spouse's name: __________________________________________

If living with partner, how long? ____________ Partner's name: __________________________________________

**Children**: #1 – Age_____ M F #2 – Age_____ M F #3 – Age_____ M F #4 – Age_____ M F

#5 – Age_____ M F #6 – Age_____ M F Are any of these step-children? ______________

**Siblings**: State the ages and gender of your siblings. Circle your place in your family of origin.
If a sibling is deceased, put an X through the placement number:

#1 – Age____ M F #2 – Age____ M F #3 – Age____ M F #4 – Age____ M F #5 – Age____ M F

Your place of birth: ______________________________________ How long did you live there? ______________

**Your Parents:** Father alive? _____ Residing where? ______________________ Relationship: _______________

Mother alive? _____ Residing where? ______________________ Relationship: ______________

Are your parents divorced? ______ If yes, how old were you when they separated? _________

Do you have step-parents? ______ If yes, since when? ____________ Relationship: _______________________

If raised by someone other than birth/step-parents, describe: ___________________________________________

Do have a deceased parent? ______ If yes, who? _______________________ How old were you? ___________

What was the cause of death? ____________________________________________________________

Have you experienced any other death(s) of significant people in your life? _______

Who? ____________________________ When? _____________________ Cause _____________________

Who? ____________________________ When? _____________________ Cause _____________________

Have you experienced any other significant losses in your life? _______ If yes, state when and describe: _______

______________________________________________________________________________________

Family of origin alcoholism? _______ Who? ___________________ When? _____________________________

Family of origin domestic violence? _______ Who? _________________ When? __________________________

Family of origin sexual abuse? _______ Who? ___________________ When? ____________________________

Share anything else in the space below that you think would be helpful for me, as your therapist, to know about your family history: ________________________________________________________________________________

______________________________________________________________________________________

**WORK HISTORY & LIFESTYLE**

Occupation __________________________________________________ How long at this position? ___________

If presently unemployed, describe reason ___________________________________________________________

If applicable, list hobbies or other regular activities you enjoy: ___________________________________________

______________________________________________________________________________________

**RELIGION**

Religious upbringing/background (if any): _______________________ Current affiliation: ____________________

Is faith an important part of your life, and if so, why? __________________________________________________

**EMOTIONAL STATE**

Are you currently experiencing strong emotions, and if yes, describe: _____________________________________

______________________________________________________________________________________

Have you experienced a childhood or other trauma?______ If yes, describe: ______________________________

______________________________________________________________________________________

Have you ever been treated for emotional disturbances, like depression, anxiety, panic, phobias, etc.? __________

If yes, describe: ____________________________________________________________ When? _____________

Have you ever had thoughts of suicide? _____ If yes, when & how often? _________________________________

Have you ever attempted suicide? _____ If yes, how many times? _____ When was the last time? ____________

**CONFIDENTIALITY AND LIMITS**

*I, the client, _____________________________________ (print client's name) understand that the information provided above is confidential and will remain in my client file in a secure location. I also understand that where the therapist is concerned for my well-being, or that of others, the therapist may find it necessary to seek help outside of the counselling relationship, with prior agreement from the client. Although medical information has been provided above, my doctor(s) will not be contacted without my prior written consent. In the case of a disclosure concerning acts of terrorism under the terrorism act, acts specific to the children's act, or acts that may cause physical harm to me or others, I am aware that confidentiality may be broken and such disclosures will be reported to the relevant authorities immediately. All notes taken during sessions will be kept confidential and securely stored at all times. I further understand that if the therapist is under clinical supervision as per CRPO requirements, she may disclose case details to the supervisor except for personal identification.*

Client's signature ________________________________________________ Date __________________________

Client's parent/guardian signature (if under 16) __________________________________ Date ________________

**FOR OFFICE USE ONLY**

First Appt.: ________________________ Term Date: ______________________ Destroy Date: _____________________