haven
counselling therapy

Client Intake Form – (Adolescent)

Please provide the following information for our records and for us to provide you the best possible care. Information on this form is completely confidential. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.

Personal & Contact Information

Full Name: _____

Pronouns: She/Her/Hers He/Him/His They/Them/Theirs

Date of Birth/Age:_____ Birthplace:_____

Full Address:_____

Home Phone: _____Ok to leave msg: Yes/No

Cell Phone: _____Ok to leave msg: Yes/No

Email Address: _____

School you attend:_____ Grade:_____

Do you currently meet with your guidance counsellor at school? Y/N (please circle)

Religious or spiritual upbringing: _____

Is this an important part of your life? Yes/No

Parental Marital status (pls circle): Married Separated Divorced Widowed Other

Mother alive? Yes/No If deceased, please note year of death: _____

Mother's profession: _____

Your relationship with mom is best described as (pls circle): Close Somewhat close Distant Conflicted

Father alive? Yes/No If deceased, please note year of death: _____

Father's profession: _____

Your relationship with dad is best described as (pls circle): Close Somewhat close Distant Conflicted

Siblings	
M/F	Age

General Health:

How would you rate your current physical health (pls circle)? Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health issues you are currently experiencing (including, but not limited to: sleep issues, headaches, stomach, heart issues, blood pressure, diabetes, weight issues, appetite, etc.):

_____

Hospitalization(s): Reason(s):_____ Date:_____

Family Physician:_____ Phone number:_____

Emergency Contact:_____ Phone number: _____

Mental Health:

Self: Any Diagnoses: _____ If yes, please specify: _____

Suicidality or self-harm (pls circle): None Thoughts Plan Means

Family Member(s): Past Diagnoses: _____ If yes, please specify relationship & diagnosis:

_____

Have you previously sought assistance from a mental health professional? _____

If yes: Name of Professional(s):_____Date(s):_____

Reason for seeking assistance:_____

Medication/Dosage	Year/Month started	Side effects/results	Reason for Prescription

History of abuse (pls circle): Verbal/emotional Physical Sexual Spiritual Other

Alcohol use (pls circle): Never Occasional Frequent Dependent

Non-medicinal drug use (pls circle): Never Occasional Frequent Dependent

Please describe your reasons for seeking therapy at this time:

_____

_____

_____

What are the issues you hope will be addressed in therapy?

_____

_____

_____