131 Union Street East.
Suite #103
Waterloo, ON
N2J 1C4

The Natural Way
HEALTH CLINIC
where healing begins

(T) 519-772-2116
(F) 866-731-5603
www.thenaturalwayclinic.com

THE NATURAL WAY HEALTH CLINIC

COUNSELLING INTAKE FORM

At The Natural Way, our treatment approach is holistic and seeks to understand all factors that may be affecting your unique situation and your health. Please answer the following questions to the best of your ability.

Name: _____ Date: _____

Date of Birth: _____ (month/day/year) Age: _____

Gender: _____ Preferred Pronouns: _____

Street Address: _____

E-mail:_____

Telephone: Cell (____)_____ Work (____)_____ Home (____)_____

What is the best way to reach you? _____

Can we leave voice mail for you? Yes / No Can we contact you by email? Yes / No

Occupation: _____ Ethnic Background: _____

Relationship Status: _____

Number of children: _____ Ages of children: _____

Number of children living at your home: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: _____

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REASON FOR SEEKING SERVICES

In your own words, describe the main reason you're seeking counselling?

Have you had thoughts of suicide in the past two years? YES / NO

GOALS

1. Please write down one or two specific goals that counselling can help you achieve:

2. How do you think your life will be different after you've completed counselling?

3. What problematic thoughts, actions, feelings, or beliefs would you like to focus on?

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EMOTIONAL SUPPORT

1. Have you ever sought counselling or therapy in the past? YES / NO

   If **yes**, please indicate what you found **helpful OR unhelpful** about previous counselling:

2. Do you have friends, family, colleagues, etc., who can provide emotional support? YES / NO

3. Are there religious or spiritual practices that are meaningful to you? YES / NO

   If **yes**, please specify (i.e., Christian, Muslim, Pagan, New Age, etc.):_____

HISTORY

1. Do you currently have or have had a mental health diagnosis? YES / NO

   If **yes**, underline/circle all areas that apply:

   BIPOLAR DISORDER BORDERLINE PERSONALITY DISORDER

   GENERALIZED ANXIETY DISORDER MAJOR DEPRESSION

   POST TRAUMATIC STRESS DISORDER (PTSD) ADDICTION

   OBSESSIVE COMPULSIVE DISORDER (OCD)

   OTHER (Please specify): _____

2. To the best of your knowledge, does anyone in your family of origin (parents, grandparents, etc.) struggle with a mental health problem? If **yes**, please specify:

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3. Have you ever been hospitalized for suicide attempt, mental health concern, or drug/alcohol abuse? If **yes**, please provide a descriptions and dates surrounding hospitalization (i.e., Suicide Attempt – Spring 2013).

4. Have you or anyone in your family previously or currently experienced challenges with addiction or substance abuse? If **yes**, please specify:

5. To your knowledge, have you experienced trauma? YES / NO
No additional details about trauma required on this form

SELF-PERCEPTION

1. On a scale of 1 to 10 please rate your general sense of self-confidence (0 = Not Confident, 10 = Very Confident):

2. Do you experience any of the following emotions *more often than most people*? (underline/circle all that apply)

Fear	Anxiety	Loneliness	Guilt	Shame
Lack of Control	Helplessness	Hopelessness	Frustration	Sadness
Anger	Depression	Tired	Rejection	

3. Please underline/circle any factors listed below that may apply to your current challenges:

Financial	Health/Medical	Anger Management	
Legal	Aging	Career/Academics	Divorce
Grief/Loss	Housing	Sexual Orientation	Relationship Issues
Violence/Trauma	Depression	Parenting	Spiritual/Religious
Stress	Low energy/motivation	Substance Use	Emotional Abuse
Eating disorder	Negative Body image	Discrimination	Isolation

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STRESS

1. Do you meditate or practice any relaxation techniques? YES / NO

2. How much do the following **stressors** impact your **daily life**?:

(Please circle the number corresponding to each, 0=No stress and 10=Worst stress.)

Work/School:	0	1	2	3	4	5	6	7	8	9	10
Family:	0	1	2	3	4	5	6	7	8	9	10
Social:	0	1	2	3	4	5	6	7	8	9	10
Finances:	0	1	2	3	4	5	6	7	8	9	10
Health:	0	1	2	3	4	5	6	7	8	9	10
Living Situation:	0	1	2	3	4	5	6	7	8	9	10
Anxiety:	0	1	2	3	4	5	6	7	8	9	10
Depression:	0	1	2	3	4	5	6	7	8	9	10

Other (Please specify: _____) 0 1 2 3 4 5 6 7 8 9 10

OTHER PROFESSIONALS

1. Please list the names and designations of any other health care providers you are seeing (medical doctor, psychiatrist, naturopathic doctor, chiropractor, etc):

MEDICATIONS/SUPPLEMENTS

1. List any **prescribed** medications you are currently taking:

2. List any **over-the-counter** medications, dietary supplements, or herbs you take on a regular basis:

3. Have you ever been prescribed **antidepressants, antipsychotics, or benzodiazepines**? If yes, please specify medication name and when it was prescribed:

4. Do you consume **alcohol, cannabis, nicotine, or recreational drugs**? If yes, please specify what you consume about approximately how often:

ADDITIONAL DETAILS

Is there anything else you would like me to be aware of?

Thank you for completing the Counselling Intake Form. Please sign and date below

Signature: _____ **Date:** _____

_____ MSW, RSW Registration #

Signature:_____ Date: _____