131 Union Street East,
Suite #103
Waterloo, ON
N2J 1B8

The Natural Way
HEALTH CLINIC
where healing begins

(T) 519-772-2116
(F) 886-731-5603
www.thenaturalwayclinic.com

COUNSELLING INTAKE FORM

Name: _____ Date: _____

Preferred name (if different from above): _____

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: _____

Religion/Spirituality: _____

Name of family doctor and/or psychiatrist: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: _____

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COUNSELLING GOALS

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

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

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

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

5. How are you currently coping with these issues?

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Please underline/circle any factors listed below that may relate to your current challenges:

Financial	Health/Medical	Anger Management	Gender Identity
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

EMOTIONAL SUPPORT

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

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

HISTORY

1. Have you had a mental health diagnosis? If **yes**, please specify:

2. To the best of your knowledge, does anyone in your family of origin (parents, grandparents, etc.) struggled with a mental health problem or addiction?

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. To your knowledge, have you experienced trauma? YES / NO
*No details required at this time

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

6. Do you use alcohol, cannabis, nicotine, or recreational drugs to cope with emotional distress? Do you have any concerns about your use of these substances?

ADDITIONAL DETAILS

Is there anything else you would like to share with me before we begin counselling?

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

Signature: _____ **Date:** _____

Kathryn Jones MSW, RSW Registration # 827265

Signature:_____ Date: _____