Family Life Centre

CLIENT INTAKE

Welcome to Tyndale Counselling Services, **the provider of psychotherapy services for the Tyndale *Family Life Centre.* Please fill in the information below to help us understand who you are and what brings you to therapy at this time. If you are unable to complete some parts, leave them blank and your therapist will assist you in completing it during your first appointment.**

1. Client Information

Client name: ________________________________ Date of birth: ____________________ Age: __________

Current address: ____

City ______________________________ Postal Code ______________________________

Contact:	Check if preferred	Voicemail?	OK to leave a discreet message?	
Cell: (_____)____________________________	☐	☐	☐ Yes	☐ No
Home/residence: (_____)__________________	☐	☐	☐ Yes	☐ No
Work: (_____)____________________________	☐	☐	☐ Yes	☐ No
Email: _________________________________	☐		☐ Yes	☐ No

Occupation (present): ____

Occupation (past): ____

Religious affiliation, if any: (present) __________________________ (past) ______________________________

Ethnic origin/cultural background: ____________________________ Country of birth: _____________________

How long in Canada: _____________________ First language: ______________________________________

MBTI type if known (optional): _____________________ Marital status: ______________________________

2. What would you like to work on? Why now?

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How troubling are the issues for you now? 1 (low) 2 3 4 5 6 7 8 9 10 (high)

3. Positive Assets You Have (i.e. strengths you are able to draw from):

____

____

4. Career Planning & Direction (i.e. any concerns in this area, direction is clear/unclear, ideas about future direction, etc.)

____

5. **Social / Relational Health**

a) How is your support network (i.e. friends, family, work, support group, church, etc.)? ________________

____

b) Who else knows about what you are experiencing now? How is it affecting other people? _____________

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6. **Past & Present Family History**

a) Significant information about relationships in your family: ______________________________________

____

b) If currently or previously married: Name of spouse: ______________________________________

Date of marriage: _________________ Date of separation/divorce: (if relevant) ___________________

Names and ages of children: ____

c) Have you experienced/witnessed domestic violence in your family? ☐ No ☐ Yes ☐ Not sure If yes:

☐ Currently: ____

☐ Past: ____

7. **Spiritual Health** (i.e. concerns in this area, challenges in integration of beliefs and behaviour, past involvement in the occult, changes in spiritual habits/disciplines, etc.) ______________________________________

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8. **Emotional / Mental Health**

Present general emotional state: (i.e. anxious, content, frustrated, confused, excited, overwhelmed, lonely, etc.)

____

Do you have a history of depression? ☐ No ☐ Yes ☐ Not sure If yes, state the details: _______________

____

Does anyone in your family have a history of depression? ☐ No ☐ Yes ☐ Not sure

If yes, state the details: ____

____

Are you presently suicidal? ☐ No ☐ Yes (If yes, Safety Plan is normally completed)

If yes, state the details: ____

____

Have you ever been suicidal in the past? ☐ No ☐ Yes If yes, state the details: _______________________

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____

Any past or present mental health concerns or diagnosis (i.e. ADHD, depression, OCD, anxiety, etc.): ☐ No ☐ Yes

If yes, state the details: ____

____

9. **Physical Health & Medical History** (i.e. regular medical checkups, past or present serious health issues, disabilities, etc.) ____

____

Have you ever had a major illness or accident? ☐ No ☐ Yes If yes, state the details: ______________

____

Are you presently taking prescribed medication(s) for a physical or mental health condition? ☐ No ☐ Yes
If yes, what are you taking, what is the dosage and for what condition? ______________________________

____

Family doctor name/location: ____________________________ Telephone number: (___)______________

Emergency contact name: ______________________________ Telephone number: (___)______________

10. Problematic Habits or Addictions

Any problematic habits or addictions present in your life? (E.g. over/under sleeping, over/under eating, Internet, pornography, smoking, drugs, alcohol, workaholism, shopping, sex, gambling, etc.) *Present:* ☐ No ☐ Yes
If yes, please explain: ____

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Past: ☐ No ☐ Yes If yes, please explain: ____

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Any addictions in your family? ☐ No ☐ Yes ☐ Not sure If yes, please explain: ____________________

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11. Incidence of Trauma or Violence in Your Life (i.e. bullying, racial discrimination, accident or witnessed an accident, traumatic medical procedure, abuse, neglect or witnessed abuse, etc.) ______________________

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12. Legal Involvement (If any current legal involvement, please provide some details.)

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13. Accessibility Services Needed (Any services you may need to help in the therapy process e.g. visual, auditory, verbal etc.)

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14. Other Relevant Information

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15. History of Therapy

a) Previous therapy with *Tyndale Counselling Services* ☐ No ☐ Yes

Tyndale Family Life Centre ☐ No ☐ Yes

If yes, with whom? ____

Was it helpful? ☐ No ☐ Yes ☐ Somewhat Please explain: ____________________________

____

b) Have you had previous therapy **outside** Tyndale? ☐ No ☐ Yes

If yes: 1) When? 2) For what reason(s)? 3) What worked? 4) What did not work?

____

____

c) Have you ever been under the care of a psychiatrist? ☐ No ☐ Yes If yes, for what reason and time period? __________________________Are you currently under the care of a psychiatrist? ☐ No ☐ Yes

d) If yes, name & phone ___________________For what reason and how long? _______________________

16. Request for Therapy

Type of therapy requested: ☐ Individual ☐ Couple ☐ Family ☐ Other

Therapy: ☐ Voluntary or ☐ Mandated ☐ Referred by: ___________________________________

If mandated, please state details (by whom, circumstances): ____

Expectations for therapy: (i.e. desired therapeutic approach or style, desire for prayer, view of therapy, etc.)

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____

17. Placement ***The following is to be filled out by Tyndale Counselling Services staff only.)***

Check one: ☐ New client ☐ Re-intake (See previous intake(s) dated: _________________________________)

Client ID # assigned: ________________________ Staff therapist: ___________________________________

Client Intake done: ☐ In person ☐ By phone ☐ Online Date of intake: _________________________

Usual day/time of appointment: __________________________ Frequency of meetings__________________________

Fee before HST:_____________ Fee with HST:_____________(to be renegotiated every 6 weeks if using sliding scale)

Combined family income, if using sliding scale: ____

# of dependents, if using sliding scale: _______________________________ Proof of income shown: ☐ Yes ☐ No

Referral source: ☐ client already knew of therapist ☐ client found therapist on website ☐ client contacted TCS for referral

☐ referred by TCS supervisor/therapist ☐ transfer from student services ☐ other (please specify) __________________

Additional information: ____

____

____

18. Discussed with client:

☐ Subsequent Appointments
☐ Avoid Dual Relationship
☐ Disclosure Information Read
☐ Procedure for Poor Fit
☐ 24 Hour Notice
☐ Informed Consent Signed
☐ How to Reach Counsellor (Voicemail/Email)
☐ Confidentiality
☐ Fees & Payment
☐ Feedback Rating Scales
☐ Facilities
☐ Goal Focus
☐ Recording
☐ FLC / TCS

19. Referrals outside TCS: ☐ Doctor ________________

☐ Other ______________________________________

19. Presenting issues: _______________________________

____

Intake Form completed by: *(check* ***ALL*** *that apply)*

☐ Client

☐ Therapist (red ink – with exception of signature)

☐ Other ___________________________