Encounter
Counselling Services

Intake Information

Please complete the following questionnaire. The information will be kept strictly confidential and used to help determine our counselling goals / treatment plan.

Identification Information Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____

Telephone Numbers: Home: _____ Cell: _____ Work: _____

May I leave a message at home? ☐ Yes ☐ No At Work? ☐ Yes ☐ No

Can you be reached by Email? ☐ Yes ☐ No Email Address: _____

When is the best time and way to contact you? _____

Occupational Information

Occupation: _____

Employer: _____

Highest level of education: _____

How satisfied are you with your job? _____

What other jobs have you held in the past? _____

_____

Personality Information

Check any of the following words which best describe you **at this point in life:**

☐ Active	☐ Ambitious	☐ Self-Confident	☐ Persistent	☐ Nervous	☐ Hardworking	☐ Impatient
☐ Moody	☐ Often Blue	☐ Excitable	☐ Imaginative	☐ Calm	☐ Serious	☐ Easy-Going
☐ Shy	☐ Good Natured	☐ Introvert	☐ Extrovert	☐ Likeable	☐ Leader	☐ Quiet
☐ Phony	☐ Lonely	☐ Submissive	☐ Self-Conscious	☐ Cynical	☐ Hopeless	☐ Optimistic
☐ Sensitive	☐ Alone	☐ Frightened	☐ Abandoned	☐ Broken	☐ Angry	☐ Solid
☐ Worthless	☐ Desperate	☐ Other: _____				

Are these descriptive words different now than usual? If so, please explain:

_____

_____

Are there things that you used to do, or would like to do, but currently do not? ☐ Yes ☐ No

_____

What do you enjoy doing in your spare time?

_____

_____

How would you describe your spiritual or religious beliefs?

_____

Marriage and Family Information

Marital / Relationship Status (check all that apply):

☐ Married ☐ Divorced ☐ Remarried ☐ Widowed

☐ Single ☐ Separated ☐ Living Together ☐ Long-term Relationship

☐ Other: _____

Current partner's name: _____

Partner's occupation: _____

Length of relationship: _____

How satisfied are you with this relationship? _____

Do you have any children (biological, adopted, foster, step, etc)? ☐ Yes ☐ No

If yes, please list names and ages:

_____

_____

_____

Do your children currently live with you? ☐ Yes ☐ No

If no, where do they live? _____

How often do you see them? _____

Have you had any other previous marriages or partnerships? ☐ Yes ☐ No

If Yes, explain briefly

_____

Is there anything else you think would be important for me to know about you or your family history?

_____

_____

_____

_____

_____

Personal and Medical History (All information gathered is held in strict confidence)

Have you ever attempted suicide? ☐ Yes ☐ No

If Yes, please describe briefly:

_____

_____

Have you ever seriously contemplated suicide? ☐ Yes ☐ No

Are you currently having suicidal thoughts? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If Yes, please describe your use of alcohol (specifically, how often, how much, and under what circumstances)

_____

_____

Do you have any chronic illnesses, medical conditions, or injuries? ☐ Yes ☐ No

If Yes, please describe:

_____

_____

_____

_____

Are you presently taking any medication? ☐ Yes ☐ No

If Yes, please list:

_____

_____

What is the name of your family doctor?

_____

When was your last visit to the doctor?

_____

Please check any of the following that presently concern you:

☐ Alcohol use	☐ Dating	☐ Guilt	☐ Nightmares	☐ Sexual abuse
☐ Addictions	☐ Decisions	☐ Headaches	☐ Parenting	☐ Sexual problems
☐ Anger	☐ Depression	☐ Health problems	☐ Parents	☐ Sexuality
☐ Anxiety	☐ Divorce	☐ Identity	☐ Physical abuse	☐ Shyness
☐ Appetite	☐ Drug use	☐ Inferiority	☐ Pregnancy	☐ Spirituality
☐ Assertiveness	☐ Education	☐ In-laws	☐ Premarital	☐ Stomach problems
☐ Body Image	☐ Emotions	☐ Legal matters	☐ Relaxation	☐ Stress
☐ Boundaries	☐ Energy	☐ Loneliness	☐ Sadness	☐ Suicidal thoughts
☐ Career choices	☐ Fears	☐ Marriage	☐ School	☐ Tiredness
☐ Children	☐ Finances	☐ Memory	☐ Self-control	☐ Trauma
☐ Chronic Pain	☐ Food	☐ My past	☐ Self-esteem	☐ Trust
☐ Communication	☐ Forgiveness	☐ My thoughts	☐ Separation	☐ Work
☐ Concentration	☐ Friends	☐ Nervousness		
☐ Conflict	☐ Grief	☐ Other: _____		

Counselling Goals

Briefly describe your reason(s) for seeking help at this time:

_____

_____

_____

_____

Do you know when your problem began? If so, explain:

_____

_____

_____

Have you ever been in therapy before? ☐ Yes ☐ No

If Yes, briefly describe the reason(s), date(s), therapist / counsellor(s) and length of treatment:

_____

_____

Was it a positive experience? ☐ Yes ☐ No

What did you like / not like about your past experience?

_____

_____

What do you wish to accomplish through this counselling process?

_____

_____

_____

_____

Approximately how many visits do you think it will take?

_____

Please print and bring this document with you, or save a copy and email it to me ahead of time:
sandi@encountervernon.ca
I will have a blank paper copy available for you to complete by hand if you prefer.