ABMA COUNSELLING SERVICES
Confidential Client Information Form

Please use this form to provide your therapist with some basic information before your first appointment. ***The information is confidential and will not be shared with anyone without your written consent.***

Today's Date: _____

Name of Client:_____ DOB: _____ Age: _____
Guardian Name (if applicable): _____
Address: _____ Postal Code: _____
Phone: _____ Email: _____

Emergency Contact:
Person to alert in the event of a medical emergency: _____
Relationship to you:_____ Phone: _____
Family Doctor: _____ Phone: _____

Referral Information:
Referred by: Internet search _____ Other (please specify): _____

General Information:
Current Occupation/Studies: _____
Relationship Status: _____
Name of Spouse/Partner: _____ Years in relationship: _____
Children (name/age): _____

Reason For Counselling:
What main concern would you like to address in therapy? _____
_____
_____

How has this affected your life? _____
_____
_____

How long have you been experiencing this challenge? _____

List any strategies you've used to try to cope with/overcome this challenge: _____
_____
_____

Symptoms:
Indicate “Yes” if you have you experienced any of the following:

	Current	*Past*
• Depressed mood	_____	_____
• Anxiety	_____	_____
• Phobias	_____	_____
• Panic attacks	_____	_____
• Angry outbursts	_____	_____
• Sleep disturbances	_____	_____
• Memory loss	_____	_____
• Overuse of alcohol	_____	_____
• Overuse of food	_____	_____
• Addictions (_____)	_____	_____
• Suicidal Thoughts	_____	_____
• Intrusive thoughts (obsessions)	_____	_____
• Obsessive behaviors	_____	_____
• Mood swings	_____	_____
• Hallucinations	_____	_____
• Frequent body complaints	_____	_____
• Body image problems	_____	_____
• Intrusive memories	_____	_____
• Loss of appetite	_____	_____
• Social withdrawal	_____	_____
• Other _____	_____	_____

Medical History
Have you had previous psychological care or counselling? If yes (a) when and (b) describe the reason for seeking counselling previously: _____
_____

Have you ever received a diagnosis for a mental health-related concern? If yes, what was the diagnosis? _____

Please provide the name and dosage of any medication you are taking:
_____
_____

Have you ever been hospitalized for psychological problems? If yes, when?
_____
_____

Have you had any significant or traumatic experiences that cause you concern at this time?

_____

_____

If applicable, please note any addictive behavior (e.g. alcohol/substance abuse) and/or mental health concerns (e.g. depression/anxiety) in your present family or family of origin:

_____

_____

Physical Health Information

Do you have any medical conditions that are affecting your daily life:(ex. chronic illness, chronic pain, traumatic injury, severe allergies, surgeries). Please provide dates when possible:

_____

_____

List any past physical health concerns:

_____

_____

List current medications (if any):

_____

_____

Have you ever been in an automobile accident or head injury that is contributing to your current condition? Describe:

_____

_____

Is there any other information about yourself or your life circumstances that is important for us to know?

_____

_____

_____

Thank you for completing this Intake Form.

1. ***Save this form to your computer by either:***
    a. ***Scrolling to the top of the form and choosing the download icon***  ***that appears on the top right of your browser window, or***
    b. ***Right-click and select 'Save As'.***
    c. ***Save Your Form as* "(Your Name) Intake Form"**
2. ***Email the form as an attachment to info@abmacounselling.com.***
3. ***Questions about how to send this form? Text or call us at 905-321-0550.***