Client Intake Form

Denise Sargeant Therapy Services

Personal Information: ___ Male ___ Female

Full Name: _____ DOB _____ Age: _____

Address: _____ Postal Code: _____

Home Phone: _____ **Message OK?** ___ Yes ___ No

Work/Alternative #: _____ **Message OK?** ___ Yes ___ No

E-mail Address: (Optional) _____

Occupation/Profession: _____ How Long? _____

If presently unemployed, describe the situation: _____

_____

Education Level:

___ None ___ Grades 1-4 ___ Grades 5-8 ___ Grades 8-12 ___ Post-Secondary

Religious Upbringing: _____ Present Affiliation: _____

Is this an important part of your life? Y / N

Marital Status: _____ # of marriages: _____ Spouse's name: _____

Living with a partner? Y / N How long? _____ Partner's name: _____

Education level of spouse/partner:

___ None ___ Grades 1-4 ___ Grades 5-8 ___ Grades 8-12 ___ Post Secondary

Dependents in home (children, elders, etc.)

Name	Relationship	Age

Family Physician: _____ Phone #: _____

Medications: _____

Mental Health Problems: _____

Reason for Present Service

Reason for counselling: _____

_____

What I would like to change/Issues I want to address: _____

_____

_____