ME First Wellness Professional Counselling

Address: 606 33rd Street West **Business: (306) 281-6674**
Saskatoon, SK S7L 0W1

Intake Form

Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ Age: _____

Address: _____ Postal Code: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Messages ok? Yes No Messages ok? Yes No Messages ok? Yes No

Emergency contact and phone number : _____

Family Physician: _____ Referred by: _____

Occupation: _____ Marital Status: _____

Partner's Name: _____

Children(s)'s Name(s): _____

What is your primary reason for seeking counselling at this time?
_____

How long has this been a concern? _____

What help or supports have you already tried for this concern?
_____

What are your goals for counselling?
_____

What are your current coping mechanisms?
_____

What are your strengths?
_____

What are your interests (ie. Things you do for fun and relaxation)?
_____

Indicate if you experience or have experienced the following, by checking beside the relevant items

_____Anxiety
_____ Distracted/forgetful
_____ Substance Use
_____ Pain (headaches, stomachaches, etc.)
_____ Startle easily
_____ Accident prone
_____ Difficulties with organizing, planning
_____ Mood swings
_____ Digestive problems
_____ Sensitivity to light and/or sounds
_____ Recurring dreams or nightmares
_____ Hyperactivity/restlessness
_____ Emotionally subdued
_____ Aggression
_____ Feelings of shame and/or guilt
_____ Exaggerated emotions
_____ Self-harming behaviors (cutting, scratching, burning)
_____ Suicidal thoughts or attempts
_____ Other (please specify) _____.

_____ Avoidance behaviour
_____ Attraction to dangerous situations
_____ Thrill seeking
_____ Concentration difficulties
_____ Irritability
_____ Disrupted eating patterns
_____ Stress
_____ Lethargy/exhaustion
_____ Sleep difficulties
_____ Excessive worry
_____ Coordination difficulties
_____ Easily overwhelmed
_____ Panic attacks
_____ Depression

Are you currently being treated for any medical or physical conditions? _ Yes _ No If yes, please identify the condition, any medications, and check any boxes below which are applicable to identify who is involved in your treatment.

Condition:
_____.
Medications:
_____.

Involved in treatment:

❑ physician ❑ homeopath ❑ massage therapist ❑ naturopath ❑ chiropractor ❑ physical therapist ❑ acupuncturist ❑ other : _____

History

Which of the following have you experienced? Check all that apply.

❑ Fetal distress
❑ Birth trauma
❑ Near drowning/suffocation
❑ Falls

❑ Premature birth

❑ Broken bones

❑ Major injuries or burns

❑ Prolonged immobilization (casts, braces, etc.)

❑ Surgery

❑ Life threatening or severe illness

❑ Loss of possessions (robbery, disaster, et cetera)

❑ Divorce/separation (as child or adult)

❑ Auto/bike accidents

❑ Poisoning

❑ Death of significant individual

❑ Witness to violence

❑ Abuse (verbal, physical, sexual)

❑ Other. Please list _____.

I understand that the treatment given is not a substitute for medical or psychological diagnosis. The practitioner does not diagnose conditions, nor prescribe or perform medical treatment.

Signature:_____

Witness: _____

Date: _____