***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

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_\_\_ Avoidance behaviour \_\_\_\_\_ Distracted/forgetful \_\_\_\_\_ Attraction to dangerous

\_\_\_\_\_ Substance Use situations \_\_\_\_\_ Pain (headaches, stomachaches, etc.) \_\_\_\_\_ Thrill seeking \_\_\_\_\_ Startle easily \_\_\_\_\_ Concentration difficulties

\_\_\_\_\_ Accident prone \_\_\_\_\_ Irritability \_\_\_\_\_ Difficulties with organizing, planning \_\_\_\_\_ Disrupted eating patterns

\_\_\_\_\_ Mood swings \_\_\_\_\_ Stress \_\_\_\_\_ Digestive problems \_\_\_\_\_ Lethargy/exhaustion \_\_\_\_\_ Sensitivity to light and/or sounds \_\_\_\_\_ Sleep difficulties

\_\_\_\_\_ Recurring dreams or nightmares \_\_\_\_\_ Excessive worry \_\_\_\_\_ Hyperactivity/restlessness \_\_\_\_\_ Coordination difficulties

\_\_\_\_\_ Emotionally subdued \_\_\_\_\_ Easily overwhelmed \_\_\_\_\_ Aggression \_\_\_\_\_ Panic attacks \_\_\_\_\_ Feelings of shame and/or guilt \_\_\_\_\_ Depression \_\_\_\_\_ Exaggerated emotions

\_\_\_\_\_ Self-harming behaviors (cutting, scratching, burning)

\_\_\_\_\_ Suicidal thoughts or attempts

\_\_\_\_\_ Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

If you enter treatment with us for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? [] Yes [] No

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 ❑ Near drowning/suffocation ❑ Birth trauma ❑ Falls ❑ Premature birth ❑ Auto/bike accidents ❑ Broken bones ❑ Poisoning

❑ Major injuries or burns ❑ Death of significant individual

❑ Prolonged immobilization (casts, braces, etc.) ❑ Witness to violence

❑ Surgery ❑ Abuse (verbal, physical, sexual)

❑ Life threatening or severe illness

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

❑ Divorce/separation (as child or adult)

❑ 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: \_\_\_**Urban Morelli (digital signature**\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_