Counselling Intake Form

Personal Information

Name & Surname: _____ DOB: _____

Employment Status: Employed ☐ Self-employed ☐ Unemployed ☐

Current Employer (if applicable) _____

Position: _____

How were you referred? _____

Landline No. (if applicable) _____ Cell phone No: _____

Email address: _____

Preferred method of contact: E-mail ☐ Landline No. ☐ Cell phone No. ☐

Postal Address: _____

_____

City/Town: _____ Province: _____

Postal code: _____

Emergency Contact Information

Name & Surname: _____

Contact No: _____

Email Address: _____

Relationship: _____

Medical History

Mark with an X those that are applicable to you if a medical diagnosis was made:

Allergies		Coronary heart disease	
Anaemia		Depression	
Asthma		Osteoporosis	
Angina (chest pain)		Seizures	
Anxiety		Arthritis	
Diabetes		Blood clots	
Emphysema		Myocardial infarction (heart attack)	
Hypertension (High Blood Pressure)		Liver disease	
Cancer		Hepatitis (Liver inflammation)	
Renal disease		Peptic ulcer (Stomach ulcer)	
Irritable Bowel disease		Migraine headaches	
Thyroid disease		Other	

Have you had any surgeries in the last five years? (Yes/No), Explain briefly.

Family History

Mark with an X for those that are applicable to you:

Adopted ☐ Alcoholism ☐ Allergies ☐ Asthma ☐ Arthritis ☐ Blood Disease ☐

Coronary Artery Disease (Narrowing of arteries) ☐ Developmental Delay ☐

Obesity ☐ Diabetes ☐ Eczema ☐ Hearing Impairment ☐ Cancer ☐

Hyperlipidaemia (High Cholesterol) ☐ Hypertension (High Blood Pressure) ☐

Irritable Bowel Disease ☐ Learning Disability Mental Illness ☐

Osteoporosis ☐ Tuberculosis ☐ Osteoarthritis ☐ Renal Disease ☐

Peripheral Vascular Disease (narrowing blood vessels) Other

Do you use tobacco or other products (vape, e-cigarettes etc.)

No ☐ Daily ☐ Weekly ☐ Occasional User ☐ Former user ☐

Do you use alcohol?

No ☐ Daily ☐ Weekly ☐ Occasional User ☐ Former user ☐

How often do you consume caffeine/products (e.g. Red Bull)

No ☐ Daily ☐ Weekly ☐ Occasional User ☐ Former User ☐

Presenting situation: *(Please state in your own words the main reason for seeking counselling.)*

On the scale below, state the severity of the situation.

Mildly upsetting ☐ Moderately upsetting ☐ Extremely upsetting ☐

Have you seen a counsellor, psychologist, psychiatrist, or any other mental health professional before? (Yes/No) If yes provide more information (when, where, duration, reasons)

Personal and Social History

Marital Status

Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed ☐

Name of spouse (if applicable) _____

Length of marriage (if divorced or widowed) _____

Children (if applicable) List by names, age, and gender

1._____

2._____

3._____

4._____

5._____

6._____

Age of your biological father if still living _____

State of his health (good/ poor /satisfactory) _____

If deceased, age at the time of his death_____

Your age at the time of his death (if applicable) _____

Cause of his death (if applicable) state natural if you do not wish to disclose.

_____

Age of your biological mother if still living _____

State of her health (good/ poor /satisfactory) _____

If deceased, age at the time of her death_____

Your age at the time of her death (if applicable) _____

Cause of her death (if applicable) state natural if you do not wish to disclose.

_____

List by **name and age** your siblings (if applicable)

1._____

2._____

3._____

4._____

5._____

6._____

7. _____

List any mental health history in your family of origin- E.G. Parents, siblings, grandparents. (E.G. depression, anxiety, PTSD)

List any traumatic events in your childhood and or adulthood. (state event and year)

Educational History

Highest level of education achieved.

School leaver ☐ Matric ☐ Undergraduate ☐ Post-Graduate ☐

Doctoral ☐

Field of study: _____

Are you experiencing any challenges or stressors in your current job? Explain very briefly.

Health History

Do you have any current health concerns? (Yes/No) If yes, explain briefly.

Name of Primary healthcare provider: _____

Telephone Number: _____

Are you on any prescription or chronic medication? (if yes, please list these)

Do you exercise? (State what form and how often)

On average, how many hours of sleep do you get per night.

Have you been diagnosed with any sleep disorders?) If yes, give more details)

List any concerns you may have of your eating habits.

Have you had any unexplained weight loss or weight gain in the last 3 to 6 months? (Yes/No)

Have you sought medical help for this? (State Yes/No) If yes, give information on medical findings.

Feelings: Mark with an X any specific behaviours/feelings you would like to change.

Anger		Hopelessness	
Guilt		Panicky	
Bitterness		Envy	
Unhappiness		Restlessness	
Regret		Depressive Episodes	
Boredom		Pessimism	
Fear		Lethargy	
Tense		Over-Energetic	
Loneliness		Procrastination	
Anxiety			

Physical: Mark with an X the following symptoms that apply to you.

Headaches		Fatigue	
Stomach cramps		Twitches	
Skin problems		Chest pains	
Dizziness		Tension in back	
Dry mouth		Rapid heart rate	
Palpitations			

Behaviours: Mark with an X the following behaviours that apply to you:

Over-eating		Gambling	
Under-eating		Concentration Difficulties	
Vomiting		Social avoidance	
Cigarette smoke		Lack of motivation	
Consume alcohol.		Cry often	
Take recreational drugs.		Compulsions	
Take medicinal drugs.		Dangerous risk-taker	
Impulsivity		Aggressive behaviour	
Loss of control		Outbursts of anger	
Phobias			

Have you been convicted of a criminal offense? (Yes/No) Explain briefly.

What outcomes are you hoping for from counselling?

Additional comments or concerns:

Your signature below indicates that the information that you have provided is truthful.

Client's signature: _____Date: _____