

CLIENT INTAKE FORM – COBA Counselling & Consulting

Self: <input type="checkbox"/> Male <input type="checkbox"/> Female		Partner: <input type="checkbox"/> Male <input type="checkbox"/> Female
Surname		
First Name		
Date of Birth	Mm/dd/yy	Mm/dd/yy
Address		
Postal Code		
Home Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No Message OK?	
Work Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No Message OK?	
Alternative #	<input type="checkbox"/> Yes <input type="checkbox"/> No Message OK?	
Employer	<input type="checkbox"/> Fulltime Employ <input type="checkbox"/> Social Assistance <input type="checkbox"/> Employ Insurance <input type="checkbox"/> Retired/Disability <input type="checkbox"/> Student <input type="checkbox"/> Self-Employed <input type="checkbox"/> PT Employment <input type="checkbox"/> Homemaker <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Fulltime Employ <input type="checkbox"/> Social Assistance <input type="checkbox"/> Employ Insurance <input type="checkbox"/> Retired/Disability <input type="checkbox"/> Student <input type="checkbox"/> Self-Employed <input type="checkbox"/> PT Employment <input type="checkbox"/> Homemaker <input type="checkbox"/> Other (Specify) _____
Occupation/ Profession	Title/Employer	Title/Employer
Ethnicity Identification	<input type="checkbox"/> Canadian <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Canadian <input type="checkbox"/> Other (Specify) _____
Religious Affiliation	<input type="checkbox"/> Practicing (optional-Church/Faith: _____) <input type="checkbox"/> Non-Practicing	<input type="checkbox"/> Practicing (optional – church/faith: _____) <input type="checkbox"/> Non-Practicing

Children and Other Dependants in Home (elders, pets, etc.) (complete on back if required)

Name	Relationship (son/daughter/step)	Date of Birth Mm/dd/yy
	<input type="checkbox"/> Full Custody _____ % Custody	
	<input type="checkbox"/> Full Custody _____ % Custody	
	<input type="checkbox"/> Full Custody _____ % Custody	
	<input type="checkbox"/> Full Custody _____ % Custody	

<p>Referred By: <input type="checkbox"/> Self <input type="checkbox"/> Peer/Friend <input type="checkbox"/> Phone Book <input type="checkbox"/> Doctor <input type="checkbox"/> Other Client <input type="checkbox"/> Family <input type="checkbox"/> Internet <input type="checkbox"/> Media <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Print Medium <input type="checkbox"/> Agency _____</p> <p>Relationship Status (self): <input type="checkbox"/> Married <input type="checkbox"/> Cohabiting <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed</p> <p>Education Level: (self): <input type="checkbox"/> None <input type="checkbox"/> Grades 1-4 <input type="checkbox"/> Grades 5-8 <input type="checkbox"/> Grades 8-12 <input type="checkbox"/> Post Secondary _____ (spouse): <input type="checkbox"/> None <input type="checkbox"/> Grades 1-4 <input type="checkbox"/> Grades 5-8 <input type="checkbox"/> Grades 8-12 <input type="checkbox"/> Post Secondary _____</p> <p>Service for: <input type="checkbox"/> Self <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Other (Specify) _____</p>

General Medical Condition:

Family Physician: _____ Phone #: _____

Medical Conditions (Check Applicable):
 Sleep Issues Headaches Stomach Heart Issues Blood Pressure Weight Issues Appetite
 Shortness of Breath Diabetes Thyroid Other _____ (add further info on back as necessary)
Hospitalization (especially head injury):Reason(s): _____ Dates: from ____/____/____ to ____/____/____
month year month year**Mental Health History**
Self: Past Diagnosis (Specify) _____ (Depression, Schizophrenia, OCD, etc)
 Suicidality or Self Harm: None Thoughts Plan Means
Family Member(s): (Specify) _____

Past Diagnosis (Specify) _____ (Depression, Schizophrenia, OCD, etc)

Suicide: Attempt Completion (Specify) _____

Medication/Dosage <small>(additional on back of page)</small>	Year/Month 1 st Given	Side Effects/Result	Reason

History of abuse (physical, mental, emotional, sexual): Yes NoAlcohol Use never rarely regularly frequently excessiveNon-Medicinal Drug Use never rarely regularly frequently**Previous Professional Mental Health Assistance:**

Name of Professional	
Dates (mm/yy)	
Reason for Service	
Benefit	
Detriment	

Reason For Present Service”Reason for Counseling:

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

