FERNIE COUNSELLING & CONSULTING

ADULT INTAKE

PERSONAL INFORMATION

Name _____

Address _____

City _____ Province _____ Postal Code _____

Phone _____ Cell _____

Email _____

Date of Birth _____

EDUCATION

Highest Grade you completed _____ College Student? Yes ◯ No ◯

What College _____

EMPLOYMENT

Do you work outside the home? Yes ◯ No ◯ Disability? Yes ◯ No ◯

Place of Employment _____

SPOUSE OR PARTNER INFORMATION

Name _____

Address _____

City_____ Province _____ Postal Code _____

Phone _____ Cell _____

Email _____

Date of Birth _____

EDUCATION

Highest Grade they completed ____College Student? Yes ◯ No ◯

What College _____

EMPLOYMENT

Does your Spouse or partner work outside of the home? Yes ◯ No ◯

Disability? Yes ◯ No ◯

Place of Employment _____

CHILDREN

Children ____

Names and Ages _____

Where do they live today?

_____

Emergency Contact Person _____

Relationship to you _____ Phone _____

FAMILY BACKGROUND

Mother _____

City _____ Province _____

Occupation _____

Father _____

City _____ Province _____

Occupation _____

Siblings (name and age) _____

Did anyone else raise you? (Nanny, Auntie, Grandmother etc.) _____

Why? _____

HISTORY

List all of the places that you lived:

Which one was favorite _____

Which one was your least favorite _____

ABOUT YOU

List your favorite activities:

What brings you joy?

What is your least favorite thing to do?

List your fears

Have you ever been to Therapy before? Yes ◯ No ◯

Length of time _____

What do you hope to accomplish in therapy?

Were you: (in your childhood and/or as an adult)

Sexually Abused _____

Physically Abused _____

Verbally Abused _____

Psychologically Abused _____

Ritually Abused _____

What Medications are you currently taking:

What Herbal remedies are you currently taking:

How do you cope with stress?

Do you have a problem with Porn?_____

Would your partner or family agree with you? Yes ◯ No ◯

Do you have a problem with Drinking?_____

Would your partner or family agree with you? Yes ◯ No ◯

Do you have a problem with drugs?_____

Would your partner or family agree with you? Yes ◯ No ◯

Do you have a problem with cutting?_____

Would your partner or family agree with you? Yes ◯ No ◯

Do you have a problem with an eating disorder?_____

Would your partner or family agree with you? Yes ◯ No ◯

Do you have a gambling or spending problem?_____

Would your partner or family agree with you? Yes ◯ No ◯

Is there a reoccurring complaint about you that a partner, spouse, or family member makes?

How are you feeling?

Have you ever been in a 12 Step Program? Yes ◯ No ◯

Which one?_____

Have you ever admitted yourself or been admitted to:

- ☐ Inpatient Psychiatric Facility
- ☐ Drug and Alcohol Treatment Facility
- ☐ Detox Center
- ☐ Eating Disorder Treatment Facility
- ☐ Other Treatment Facility (DID, PTSD, Gambling, etc)

What is your drug of choice? _____

What is your fall-back addiction? _____

How long have you been clean and sober? _____

Do you have a sponsor? Yes ◯ No ◯

Have you ever attempted Suicide? Yes ◯ No ◯

When?_____

Were you hospitalized? Yes ◯ No ◯

Where?_____

Are you suicidal now? Yes ◯ No ◯

If so, what is keeping you alive at present?