Lifewater Counselling - Intake Information

Please complete the following questionnaire. This information will be kept strictly confidential and used to help determine our counselling goals/treatment plan.

Identification Information Today's Date: _____

Name: _____ Date of Birth: _____

Address:_____

Telephone Numbers: Home: (___)_____Cell: (____) _____Work: (___) _____

Can I leave a message at home? ☐ YES ☐ NO at Work? ☐ YES ☐ NO

Can you be reached by Email? ☐ YES ☐ NO Email Address: _____

When is the best time and way to contact you? _____

Occupational Information

Occupation: _____

Employer: _____

Highest level of education:

_____

How satisfied are you with your job?

_____

What other jobs have you held in the past?

_____

Personality Information

Circle any of the following words which best describe you **at this point in life**:

Active	Ambitious	Self-Confident	Persistent	Nervous	Hardworking	Impatient
Moody	Often Blue	Excitable	Imaginative	Calm	Serious	Easy-Going
Shy	Good-Natured	Introvert	Extrovert	Likeable	Leader	Quiet
Phony	Lonely	Submissive	Self-conscious	Cynical	Hopeless	Optimistic
Sensitive	Alone	Frightened	Abandoned	Broken	Angry	Solid
Worthless	Desperate	Other: _____				

Are these descriptive words different now than usual? If so, please explain:

_____

_____

Are there things that you used to do, or would like to do, but currently don't?

_____

What do you enjoy doing in your spare time?

_____

_____

How would you describe your spiritual or religious beliefs?

_____

Marriage and Family Information

Marital/Relationship Status (check all that apply):

☐ Married ☐ Divorced ☐ Remarried ☐ Widowed ☐ Separated
☐ Single ☐ Long-term Relationship ☐ Living Together ☐ Other _____

Current partner's name:

_____

Partner's occupation:

_____

Length of relationship:

_____

How satisfied are you with this relationship?

_____

Do you have any children (biological, adopted, foster, step, etc.)? ☐ YES ☐ NO

If yes, please list names and ages:

_____

_____

_____

Do your children currently live with you? ☐ YES ☐ NO

If no, where do they live?

_____

How often do you see them?

_____

Have you had any other previous marriages or partnerships? ☐ YES ☐ NO

If Yes, explain briefly:

_____

Is there anything else you think would be important for me to know about you or your family history?

_____

_____

_____

_____

_____

Personal and Medical History (All information gathered is held in strict confidence.)

Have you ever attempted suicide? ☐ YES ☐ NO

If yes, please describe briefly:

_____

_____

Have you ever seriously contemplated suicide? ☐ YES ☐ NO

Are you currently having suicidal thoughts? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

If yes, please describe your use of alcohol (specifically, how often, how much, and under what circumstances).

_____

Do you use mood-altering drugs? ☐ YES ☐ NO

If yes, please describe your use of mood altering drugs (how often, how much, and under what circumstances).

_____

_____

Do you have any chronic illnesses, medical conditions, or injuries? ☐ YES ☐ NO

If yes, please describe:

_____

_____

_____

_____

Are you presently taking any medication? ☐ YES ☐ NO

If yes, please list:

_____

_____

What is the name of your family doctor?

_____

When was your last visit to the doctor?

_____

Please circle any of the following that presently concern you:

Assertiveness	Parenting	Bowels	Nightmares
Bedwetting	Nervousness	Physical abuse	Education
Temper	Stress	Memory	Headaches
Unhappiness	Premarital	In-laws	Health problems
Alcohol use	Sexual problems	Loneliness	Ulcers
Energy	Children	Divorce	Depression
Inferiority	Drug Use	Finances	Fears
Food	My past	Career choices	Legal matters
Marriage	Concentration	My thoughts	Sleep
Parents	Relaxation	Sexual abuse	Friends
Headaches	Appetite	Work	Self-control
Guilt	Stomach problems	Self-concept	Religion
Separation	Suicidal thoughts	Decision making	Insomnia
Ambition	Shyness	Dating	Tiredness
School	Confusion	Sadness	Other _____

Now please put an * beside the items that are concerning you MOST.

Counselling Goals

Briefly describe your reason(s) for seeking help at this time:

_____

_____

_____

_____

Do you know when your problem began? If so, explain:

_____

_____

_____

Have you ever been in therapy before? ☐ YES ☐ NO

If yes, briefly describe the reason(s), date(s), therapist/counselor(s) and length of treatment:

_____

_____

Was it a positive experience? ☐ YES ☐ NO

What did you like/not like about you're past experience?

_____

_____

What do you wish to accomplish through this counselling process?

_____

_____

_____

_____

Approximately how many visits do you think it will take?

_____