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Adult Intake Form

The following background information is required to ensure you receive comprehensive care

Client Information

Name: _____

Gender: _____

Date of Birth: M_____D_____Y_____

Relationship Status:

Age: _____ _____

Phone: _____ Do you have children:

_____

E-mail: _____

Preferred method of communication: ☐Call ☐Text ☐E-mail

Contact Information

Emergency Contact: _____ Emergency Contact # _____

Spouse Information:

Name: _____ Age: _____

Sibling(s) /Step Sibling(s) Information:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Child/Children Information:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Custody/Living Arrangement:

Is there a custody arrangement in place? NO YES

If yes, is the custody shared, sole support or other: _____

Who does your child/children live with primarily: _____

If there is a custody and access agreement what is the visitation schedule?

_____

_____

_____

Health Information:

Family Physician: _____ Date last seen: _____

Psychiatrist: _____ Date last seen: _____

How would you rate your current physical health? (Circle):

☐ Very Poor ☐ Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐ Excellent

Please explain:

_____

_____

Has a medical practitioner made any formal or working diagnosis of you? ☐YES ☐NO
Please provide details:

_____

_____

Are you currently in treatment for any medical problems? ☐YES ☐NO
Please provide details:

_____

_____

Have you had any serious illnesses/accidents/surgeries in the past? ☐YES ☐NO
Please provide details:

_____

_____

Please list all medications currently prescribed including dosage:

_____

_____

Do you or have you ever struggled with alcohol/drug use/abuse ☐YES ☐NO
Please provide details:

_____

_____

Have you ever had psychiatric treatment or counseling? ☐YES ☐NO
Please provide details:

_____

_____

Is there a family history of psychiatric illness? ☐YES ☐NO
Please provide details:

_____

_____

Have you had previous suicidal ideation? ☐YES ☐NO ☐Prefer not to answer

Have you had previous suicide attempts? ☐YES ☐NO ☐Prefer not to answer

Have you had previous experiences of self-harm? ☐YES ☐NO ☐Prefer not to answer

On a scale of 1-10 (1: not concerned - 10: extremely concerned) How concerned are you currently about the possibility of suicide: _____ ☐Prefer not to answer

Please provide details:

_____

_____

Employment Information

Employment status?
☐Full-time ☐Part-time ☐Unemployed ☐Laid off/ on leave ☐Student

Where do you work? _____

Position: _____

When did you start at this place of employment? _____

What type of work do you do / what is your role in this position:

_____

_____

Request for Social Work counseling services

Please describe the presenting concerns/reason for seeking counseling services?

_____

_____

_____

_____

How long have these concerns existed?

_____

_____

Are you currently experiencing difficulties with any of the following?

☐ eating patterns ☐ sleeping patterns ☐ chronic pain

Please provide details:

_____

_____

Are you currently experiencing any of the following?

☐ anxiety ☐ panic attacks ☐ phobias

Please explain:

_____

_____

Please provide details and dates of any significant events/stressors you've experiences
Examples: losses, births, deaths, moves, hospitalizations, financial concerns, separation, divorce …

_____

_____

_____

Have you ever had counselling before? ☐YES ☐NO

Where did they receive counselling? _____

Type of provider: _____

Name of counsellor: _____

What was the counselling concerning?

_____

_____

When did you receive these services and when did they end?

_____

_____

What would you like to accomplish with your time in therapy?

_____

_____

Do you consider yourself to be spiritual or religious? ☐YES ☐NO

Please describe your faith and what this means to you:

_____

_____

Are you comfortable with discussions regarding to God?

_____

_____

Is there anything else that you would want the Social Worker to know before your appointment?
Please explain:

_____

_____

_____

Insurance

Do you / your partner have insurance that covers Social Work Services? ☐YES ☐NO

Please note, the payment for the service is due on the day of the service, I provide you with an invoice to submit to your insurance for reimbursement, I am able to bill direct to Green Shield Canada

If you are covered by Green Shield Canada, please provide all information on your benefit card:

Employee's Name: _____ Policy #: _____

Employer's Name: _____

I give authorization to Angelina Halpern to submit to my insurer, Green Shield Canada,for direct billing of Master of Social Work Services rendered

Name: _____

Signature_____

Date: _____