Ponoka Family & Community Support Services
CONFIDENTIAL Counseling Intake Form

Date of Intake:_____

Client Name(s): _____ Ages: _____

_____

_____

Address: _____

_____ Postal Code: _____

Phone: Home: _____ Work: _____ Cell: _____

Referred by: _____

Previous Counselling: No: _____ Yes: _____ Dates: _____

Previous Therapist/Counselor: _____

Location: _____

Family Physician: _____ Address _____

Do you have any on-going medical concerns? Yes: _____ No: _____

If so, please explain:_____

_____

Are you taking any prescription medications at this time? Yes: _____ No: _____

If so, please identify: Medication: Condition:

_____

_____

_____

Please provide the name, age and relationship of any persons living in your household:

_____

_____

_____

_____

Please provide an estimate of your annual household income: _____

Are you currently on any social assistance:_____ If yes, please identify: _____

CONFIDENTIAL Counseling Intake Form – *pg 2*

Please check which of the following applies to you and/or your family:

____ Recent move
____ Divorce or separation within the past year
____ Work-related problems
____ School-related problems
____ Financial concerns
____ Health concerns
____ Disabled person in family
____ Serious illness within family within past year
____ Death in family. Indicate who & when: _____
____ Birth/adoption in family within past year
____ Remarriage/ or new relationship within the past year
____ Relationship conflicts with partner
____ Relationship distance with partner
____ Parenting conflicts with partner
____ Parent/Child conflicts
____ Parenting concerns
____ Unresolved stress from personal childhood
____ Concerns regarding addiction: (gambling/substance use/abuse)
____ Concerns regarding legal problems
____ Anger Problems
____ Anxiety Problems
____ Trauma
____ Sadness, grief issues
____ Depression problems
____ Behaviour problems
____ Sleep Disturbance
____ Weight Loss
____ Weight Gain
____ Lack of interest and motivation for usual pleasures/pastimes
____ Irritability
____ Moodiness
____ Crying Frequently
____ Feel Emotionally Flat or Numb
____ Can't concentrate
____ Difficulty completing tasks
____ Unusual thoughts
_____ Other _____

What 2 goals do you have in seeking counseling at FCSS today?

1)_____

2)_____

For Counselor Use ONLY: Date of contact: _____ 1st appt: _____

Fee Arrangement: _____

Session Review Date: _____ Counseling Completed Date: _____