Intake Form

CONFIDENTIAL CLIENT INFORMATION

Name:_____

Birthdate:_____ BC Medical Number:_____

Family Physician's Name: _____ Phone:_____

Your
Address:_____

_____

Your Phone:_____Email: _____

How did you hear about West Coast
Counselling?_____

_____

Best Times to Contact You:
_____

Is it okay to leave a message at the number provided:
Yes__ No__

Brief description of issue(s) affecting your life:

_____

_____

_____

_____

_____

_____

Please describe your family and living situation (include siblings, parents, step-parents and indicate who you live with or whether you live alone)

Are you taking any medication? If yes, please indicate which ones.

Use of substances: Do you drink alcohol, smoke or engage in drug using behavior? If yes, please indicate frequency of use.

Do you have thoughts of suicide? If yes, please indicate how often you have these thoughts and if you intend on carrying them out.

Additional Comments: