Mastery Of Self INC
134 Queen St East Brampton Ontario L6V 1B2
(P) 905 218-3515 (E) info@masteryofselfinc.ca
www.masteryofselfinc.ca

Intake Form:

Please provide the following information and answer the questions below.
Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name:

_____

(Last) (First) (Middle Initial)

Name of Parent or Guardian (if the child is under 18 years old):

_____

(Last) (First) (Middle Initial)

Birth Date (YYYY/MM/DAY): _____/___/__ Age: ___

Gender: _____ Gender identified_____

Marital Status:

- o Single
- o Common Law
- Relationship o Married
- o Separated
- o Divorced
- o Widowed

Please list any children/age:

_____

_____

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Address: _____

(Street and Number) _____(City) _____ (Province) _____ (Postal Code _____

Home Phone: ( ) May we leave a message: ( ) Yes ( )No

Cell/Other Phone: ( ) May we leave a message: ( ) Yes ( ) No

E-mail: _____ May we email you?
□ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):
_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner:
_____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list:
_____
_____

Have you ever been prescribed psychiatric medication?
□Yes
□ No

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Please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

_____

_____

_____

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

_____

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in:

_____

4. Please list any difficulties you experience with your appetite or eating patterns

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?

□No

□ Yes

If yes, for approximately how long?

_____

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6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□No
□ Yes
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□No
□ Yes
If yes, please describe _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □No □ Yes
If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).
Please Circle List Family Member

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Domestic Violence yes/no

Eating Disorders yes/no

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Obesity yes/no

Obsessive Compulsive Behavior yes/no

Schizophrenia yes/no

Suicide Attempts yes/no

ADDITIONAL INFORMATION:

1. Are you currently employed? □No □ Yes
If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____
_____
_____

2. Do you consider yourself to be spiritual or religious? □No □ Yes

If yes, describe your faith or belief:

_____
_____

3. What do you consider to be some of your strengths?

_____
_____
_____
_____
_____

4. What do you consider to be some of your challenges?

_____
_____
_____
_____
_____
_____
_____

5. What would you like to accomplish out of your time in therapy?

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_____
_____
_____
_____
_____
_____

Service Inquiry:

What services are you seeking? Please advise or circle as many that are applicable:

Social Work

Sexual Abuse/Sexual Assault Counselling

Anxiety

Trauma

Depression

Self-esteem

VAW

Safety Planning

Transgender

What are your counselling goals?

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Client name: _____

Client Signature: _____ Date: _____

Therapist Name _____

Therapist Signature_____ Date: _____