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INTAKE FORM

Completion of the following pages assists us in efficiently providing you with quality care. The information obtained in this document is protected within the constraints of the individual treatment and standards governing confidentiality.

Name: _____

Address: _____ City, Prov. _____ P.C. _____

E-mail Address: _____

Phone: (H) _____ (C) _____ Birth date: _____

Occupation: _____

Marital Status: Single Married Common-law Separated Divorced Widowed

How long? _____ Previous Marriages: _____

Who may we thank for referring you to Fresh Hope? _____

Religious affiliation: _____

Please give the following information about who lives with you:

Name	Relationship to you	Sex	Age

What is your current state of physical health? Poor Fair Good Excellent

Please identify any health problems you have: _____

_____

_____

Check any problems you are currently experiencing (within the last four weeks):

_____ Appetite gain _____ Appetite loss _____ Weight gain _____ Weight loss _____ Fatigue

_____ Blackouts _____ Dizziness _____ Diarrhea _____ Constipation _____ Anxiety

_____ Coughing _____ Skin sores _____ Nose bleeds _____ Headaches _____ Chills

_____ Nervousness _____ Nausea _____ Numbness _____ Trouble breathing

_____ Can't get to sleep _____ Can't stay asleep _____ Sleeping too much/too little (circle)

Do you drink coffee? _____Estimate how much in a day _____

Do you smoke tobacco? _____Estimate how many cigarettes in a day _____

Do you drink alcohol? _____How much during a drinking occasion _____

Do you gamble? _____How often? _____

Recreational drugs? _____ How often/much _____

Is anyone close to you concerned about your drinking/drug usage/gambling? _____

Do you exercise? _____ How/what? _____

How often? _____

Are you having suicidal thoughts? Yes No Sometimes Often

Is there a history of any of the following in your family (immediate & extended): Circle/mark all that apply:

depression bi-polar alcoholism drug abuse sexual abuse schizophrenia

suicide eating disorder physical abuse psychiatric illness rape

gambling ADHD/ADD untimely death other: _____

List any medications you are on and their purpose: _____

_____

_____

Date of last physical examination: _____

Have you been in counselling before? When/how long? _____

What are your present concerns? _____

_____

_____

_____