CLIENT INTAKE FORM

PERSONAL CLIENT INFORMATION

First Name: _____ Surname: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: ( )_____ Cell: ( )_____

Business: ( )_____

Health Card #: _____ Version Code: _____

S.I.N. Number: _____

Name of Insurance Company: _____

Group Policy #: _____

Date of Birth: (DD) _____ (MO) _____ (YR) _____ Gender: _____

Marital Status: Single _____ Married _____ Common Law _____

Separated _____ Divorced _____ Widowed _____

CLIENT HISTORY

Primary Counsellor: _____

Referral Source: _____

Presenting Problem: _____

Additional Problems: _____

_____

PERSONAL CONTACT INFORMATION

Name: _____ Phone #: ( )_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Relationship to Client: _____

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (eg., repeated absence or poor work performance related to substance use; related absences, suspensions, or expulsions from school; neglect of children or household)

   Yes_____ No_____

2. Recurrent substance use in situations in which it is physically hazardous (eg., driving an automobile or operating a machine when impaired by substance use)

   Yes_____ No_____

3. Recurrent substance-related legal problems (eg., arrests for substance-related disorderly conduct)

   Yes_____ No_____

4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (eg., arguments with spouse about consequences of intoxication; physical fights)

   Yes_____ No_____

1. **Tolerance, as defined by either of the following:**

a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect

yes_____ no_____

b) markedly diminished effect with continued use of the same amount of the substance

yes_____ no_____

2. **Withdrawal, as manifested by either of the following:**

a) the characteristic withdrawal syndrome for the substance

yes_____ no_____

b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

yes_____ no_____

3. **The substance is often taken in larger amounts or over a longer period than was intended**

yes_____ no_____

4. **There is a persistent desire or unsuccessful efforts to cut down or control substance use**

yes_____ no_____

5. **A great deal of time is spent in activities necessary to obtain the substance (eg., visiting multiple doctors or driving long distances), use the substance (eg., chain-smoking), or recover from its effects.**

yes_____ no_____

6. **Important social, occupational, or recreational activities are given up or reduced because of substance use**

yes_____ no_____

MEDICAL HISTORY (Please checkmark ☑ all that apply)

Allergies:	Yes___ No ___	Heart Problems:	Yes___ No ___
Diabetes :	Yes ___ No ___	Stomach Problems:	Yes ___ No ___
Headache:	Yes ___ No ___	Thyroid Problems:	Yes___ No ___
Problem Urinating:	Yes ___ No ___	Bowel Problems:	Yes ___ No ___
High Blood Pressure:	Yes ___ No ___	Breathing Problems:	Yes ___ No ___
Sexually Transmitted Diseases:	Yes ___ No ___		

Other (Please Specify): _____

_____

SUBSTANCE – SPECIFIC MEDICAL HISTORY (Please checkmark ☑ all that apply)

Concentration Problems:	Yes ___ No ___	Head Injuries:	Yes ___ No ___
Seizures:	Yes ___ No ___	Memory Problems:	Yes ___ No ___
Liver Problems:	Yes ___ No ___	Blackouts:	Yes ___ No ___
Strokes:	Yes ___ No ___	Sleep Problems:	Yes ___ No ___
HIV/AIDS:	Yes ___ No ___		

Any Current Medication (Please List)

_____

_____

ALCOHOL/DRUG HISTORY (Please checkmark ☑ all that apply)

Alcohol ☐ Cocaine ☐ Crack ☐ Heroine ☐ Methadone ☐ Codeine ☐ Percodan ☐ Dilaudid ☐
Other Prescription Opiates (Please Specify)_____

Marijuana ☐ Zanax ☐ Valium ☐ Librium ☐ Hashish ☐ Halcion ☐
Other Tranquilizers (Please Specify)_____

Fiorinal ☐ Seconal ☐ Quaaludes ☐
Other Barbiturates (Please Specify) _____

Methamphetamine (Speed) ☐ LSD ☐ Mescaline ☐ Psilocybin (Mushrooms) ☐
Other Hallucinogens (Please Specify)_____

Nitrous Oxide ☐ Special K ☐ Butyl Nitrate ☐ PCP ☐ Amyl Nitrate ☐ Ecstasy (MDMA) ☐
Other Inhalants (Please Specify)_____

Other (Please Specify):

_____

CONSENT FOR RELEASE OR AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION

I, _____ hereby authorize and request that
(Client's Name)

_____
(Counsellor's/Therapist's Name)

may release all confidential, medical, psychological, psychiatric, education and/or other appropriate information acquired in the course of my evaluations and treatment, professional information pertaining to me (or my minor children) to:

_____
(Counsellor's/Therapist's Name)

I understand that I may revoke this consent at any time by informing the above party or parties in writing. In consideration of this consent, I hereby release the above party or parties from any legal liability for the release of this information.

Client's Signature: _____

Parent's or Guardian's Signature: _____

Counsellor's or Therapist's Signature: _____

Date: _____

ATTENDANCE SHEET

DATE	SERVICE	SESSION	FEE

NOTES