



A.I.M. International Inc. Client Intake Form [CONFIDENTIAL]

Welcome to A.I.M. International Inc. Please complete the following information as such information is critical to our assessment and treatment planning.

Name: _____ Date: _____

Address: _____ Town/City: _____

Postal code: _____

Occupation: _____

Work Ph#: _____ - _____ - _____ Home Ph#: _____ - _____ - _____

Cell Ph#: _____ - _____ - _____ Please check where messages can be left: ☐ wrk ☐ hm ☐ cell

Email address: _____

Please circle: Male or Female Age: _____ Date of Birth : _____ / _____ / _____ (mm/dd/yy)

Place of birth: _____

Emergency contact: _____ Relationship to you: _____

Work Ph#: _____ - _____ - _____ Cell Ph#: _____ - _____ - _____

BILLING INFORMATION

Company: _____

Please circle one: Employee or Dependent

If a Dependent, please give Employee's name: _____

Employee Assistance Company: _____

If you work for West Fraser (Blue Ridge Lumber) please circle one : MDF Sawmill

If you work for Millar Western please circle one: Pulp Sawmill

REFERAL INFORMATION

Please tell us how you heard about A.I.M. (circle all that apply)?:

A.I.M. website Facebook You-Tube Friend Co-worker Newspaper Office Window Other

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COUNSELLING HISTORY

Have you had previous counseling? YES NO

If yes, please list who you received counseling from and for how long: _____

Reason for stopping: _____

Do you feel the issue resolved was resolved? Why or why not? _____

MEDICAL HISTORY

Name of current Physician: _____ Location: _____

Relevant medical issues: _____

Please list your current medications with the drug name(s) and length of time you have been using the medication(s): _____

Have you ever been diagnosed with a mental illness Yes No

Diagnosis: _____

Have you ever had a psychiatric assessment? Yes No Psychiatrists' name: _____

Findings: _____

ALCOHOL, DRUG and FOOD USE

Are you concerned about your alcohol and/or drug use? YES NO

Are others concerned about your alcohol and/ or drug use? YES NO

Do you have difficulty managing your alcohol and/or drug use? YES NO

Have you experienced negative consequences as a result of your use? YES NO

If yes, please describe in detail the effects the use has had on your life: _____

Have you ever suffered from an eating disorder? YES NO

If yes, can you please describe how it arose? _____

Have you received treatment for the disorder (i.e. when, where and from whom)? _____

What is the current status of your eating disorder (i.e. in maintenance, actively gaining weight etc.)? _____

SUBSTANCE USE

Please mark a "x" beside the substance(s) being used below as either recreational or addiction. Describe the pattern in which you are using them (i.e. for stress relief, insomnia, anxiety relief etc.) If the substance does not apply to you simply write N/A.

SUBSTANCE	Recreational? (Using - No Dependency).....	Addiction? (Using to gain something.....)	Pattern of use
Alcohol			
Cocaine			
Cannabis			
Sugar			
Prescribe medications (please list the names)			
Video games			
Sex			
Tobacco			
Other, please specify			

RELATIONSHIP INFORMATION

Please check one: Single ____ Divorced ____ Married ____ Widowed ____ Dating ____

If single, move to the next section please, if not continue below.

Please rate your current relationship out of 10 (with 10 being amazing and 1 being terrible): _____ /10

What needs to happen to increase your rating? _____

HOME SITUATION

If applicable, please fill out the following information regarding your child(ren) and indicate if they are living at home with you.

<i>Name</i>	<i>Sex(F/M)</i>	<i>Age</i>	<i>Biological or Stepchild</i>	<i>Living at home?</i>
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do others live in the household? Yes No If yes, what is their relationship to you? _____

Please briefly describe the problem(s) for which you seek counseling assistance: _____

As a result of counseling what are your hopes? _____

Is there any other relevant information A.I.M. should be aware of? Any other questions you have?

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SYMPTOM CHECKLIST

NAME:

DATE
