Wellness Counselling Intake Assessment

Client Information	
Client Name	
Date of Birth	
Address	
Tel	
Email	
Date	

Overview	
What has led you to seek counselling at this time?	
How long have you been having these difficulties?	
How do these difficulties affect you?	
Have you received counselling in the past? If yes, when was this?	
How have you been coping with these difficulties until now?	
What would you like to gain from counselling now?	

Vocational	
What is your occupation?	
Do you enjoy your work?	☐ Yes ☐ No
Comments:	
How many hours do you work each day?	
Do you work shifts or are you on a regular schedule?	☐ Shift work ☐ Regular schedule

Medical and Mental Health History	
Have you ever been diagnosed with an illness?	☐ Yes ☐ No
If yes, please explain:	
Have you ever been hospitalized?	☐ Yes ☐ No
If yes, for what reason?	
Have you experienced any major traumas in the past 5 years?	☐ Yes ☐ No
Comments:	
Are you currently taking any medications?	☐ Yes ☐ No
List all medications, dose and the reason(s) for each:	
Please list any vitamins, minerals, herbal or homeopathic remedies you are currently taking and amount per day:	
Have you taken any antibiotics over the past 5 years?	☐ Yes ☐ No

Family History and Wellness	
Which health conditions run in your family?	☐ Allergies ☐ Diabetes ☐ Kidney Dysfunction ☐ Alcoholism ☐ Drug Abuse ☐ Mental Illness ☐ Arthritis ☐ Gall Bladder Issues ☐ Osteoporosis ☐ Asthma ☐ Heart Disease ☐ Skin Conditions ☐ Autoimmune Disease ☐ Hypertension ☐ Ulcers ☐ Cancer ☐ Intestinal Disease
Other diseases (please list):	
Do you smoke cigarettes?	☐ Yes ☐ No
If yes, how many per day and for how long?	
Do you drink alcohol?	☐ Yes ☐ No
If yes, how often?	☐ Once a month or less ☐ 2-3 times a month ☐ 1-2 times a week ☐ 3-4 times a week ☐ daily

Do you use other recreational drugs?	☐ Yes ☐ No
If yes, which type?	
How often?	☐ Once a month or less ☐ 2-3 times a month ☐ 1-2 times a week ☐ 3-4 times a week ☐ daily
Have you ever received treatment for drug and/or alcohol dependency?	☐ Yes ☐ No
If yes, indicate which you have been treated for and when:	
Have you ever experienced any negative consequences as a result of your alcohol and/or drug use?	☐ Yes ☐ No
If yes, which areas have been impacted:	☐ Work ☐ School ☐ Financial ☐ Health ☐ Relationships ☐ Legal
Other (not listed above):	
Are there other behaviour(s) which you continue to engage in that you feel are negatively impacting your life?	
Have you ever had thoughts of suicide or attempted suicide?	☐ Never ☐ I have previously had thoughts of suicide, but have never thought about a plan ☐ I am currently having thoughts of suicide, but do not have a plan ☐ I have thought about a plan, but never acted on it ☐ I currently have a plan, and wish to act on it ☐ I have attempted suicide, but did not want to die ☐ I have attempted suicide, and really hoped to die
In the last three months	☐ I have had no thoughts of suicide ☐ I have had some fleeting thoughts of suicide ☐ I have regularly thought about suicide ☐ I think about suicide on a daily basis ☐ I think about suicide multiple times a day

Relationships	
What is your current marital or relationship status?	☐ Single ☐ Dating, not living together ☐ Live-in partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
In general, how satisfied are you in your relationship? Rate on a scale from 1-10 (1 being very dissatisfied and 10 being extremely satisfied)	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Comments:	

Housing	
What is your current living situation? (Check all that apply)	☐ Housing is adequate ☐ Dependent on others for housing ☐ Housing is dangerous/unsafe ☐ Dysfunction with living companions ☐ Homeless
List all persons currently living in your household (name and relation). Indicate "none" if you live alone.	

Lifestyle	
What level of stress do you feel you are experiencing at this time? Please rate on a scale of 1-10 (1 being low and 10 being extremely high)	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What are the major causes or factors of your stress? Check all that apply.	☐ Financial ☐ Family ☐ Spiritual ☐ Career ☐ Marriage/relationship ☐ Unfulfilled expectations ☐ Health ☐ Personal ☐ Other
If other, please explain:	
How do you experience stress? How does it manifest itself?	
What helps you to manage your stress? Do you use any coping mechanisms?	

Do you exercise?	☐ Yes ☐ No
If yes, indicate type, frequency, time of day and duration.	
Do you actively participate in any spiritual discipline? (ie. church, religious group, healing, meditation)	☐ Yes ☐ No
If yes, please explain.	
How many hours do you sleep on average each day? (including naps)	
Do you have trouble falling asleep?	☐ Yes ☐ No
Staying asleep?	☐ Yes ☐ No
What are your interests and hobbies?	
Do you vacation regularly?	☐ Yes ☐ No
When was your last vacation?	
List your top three values:	
List three things you are most grateful for:	
What is your favourite colour?	

Thank you for taking the time to complete this assessment. I look forward to meeting and talking with you further. Please note that all information provided is kept confidential and will not be shared with anyone outside your circle of care at our clinic without your written consent.

Signature:	
Signed on:	

This template was adapted from a real intake form used by therapists on Jane. Customize it to reflect your practice's policies, branding, jurisdiction, and scope of practice.