GRYBA PHILLIPS
PROFESSIONAL COUNSELLING ASSOCIATES
206-912 Idylwyld Drive North **Business: (306) 934-5898**
Saskatoon SK S7L 0Z6 **Facsimile: (306) 934-5812**

Intake Form

Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ Age: _____

Address: _____ Postal Code: _____

Home phone: _____ Cell phone: _____ Work phone: _____
Messages ok? Yes No Messages ok? Yes No Messages ok? Yes No

Emergency contact and phone number : _____

Family Physician: _____ Referred by: _____

Occupation: _____ Marital Status: _____

Partner's Name: _____

Children(s)'s Name(s): _____

What is your primary reason for seeking counselling at this time?
_____

How long has this been a concern? _____

What help or supports have you already tried for this concern?
_____

What are your goals for counselling?
_____

What are your current coping mechanisms?
_____

What are your strengths?
_____

What are your interests (ie. Things you do for fun and relaxation)?
_____

Indicate which you experience the following, by checking beside the relevant items

_____Anxiety
_____ Distracted/forgetful
_____ Substance Use
_____ Pain (headaches, stomachaches, etc.)
_____ Startle easily
_____ Accident prone
_____ Difficulties with organizing, planning
_____ Mood swings
_____ Digestive problems
_____ Sensitivity to light and/or sounds
_____ Recurring dreams or nightmares
_____ Hyperactivity/restlessness
_____ Emotionally subdued
_____ Aggression
_____ Feelings of shame and/or guilt
_____ Exaggerated emotions
_____ Self-harming behaviors (cutting, scratching, burning)
_____ Suicidal thoughts or attempts
_____ Other (please specify) _____.

_____ Avoidance behaviour
_____ Attraction to dangerous situations
_____ Thrill seeking
_____ Concentration difficulties
_____ Irritability
_____ Disrupted eating patterns
_____ Stress
_____ Lethargy/exhaustion
_____ Sleep difficulties
_____ Excessive worry
_____ Coordination difficulties
_____ Easily overwhelmed
_____ Panic attacks
_____ Depression

Are you currently being treated for any medical or physical conditions? Yes No
If yes, please identify the condition, any medications, and check any boxes below which are applicable to identify who is involved in your treatment.

Condition: _____.
Medications: _____.

Involved in treatment:

❑ physician
❑ naturopath
❑ acupuncturist
❑ homeopath
❑ chiropractor
❑ other : _____
❑ massage therapist
❑ physical therapist

History:

Which of the following have you experienced? Check all that apply.

❑ Fetal distress
❑ Birth trauma
❑ Premature birth
❑ Broken bones
❑ Major injuries or burns
❑ Prolonged immobilization (casts, braces, etc.)
❑ Surgery
❑ Life threatening or severe illness
❑ Falls
❑ Near drowning/suffocation
❑ Auto/bike accidents
❑ Poisoning
❑ Death of significant individual
❑ Witness to violence
❑ Abuse (verbal, physical, sexual)

- ❑ Loss of possessions (robbery, disaster, et cetera)
- ❑ Divorce/separation (as child or adult)
- ❑ Other. Please list _____.

I understand that the treatment given is not a substitute for medical or psychological diagnosis. The practitioner does not diagnose conditions, nor prescribe or perform medical treatment.

Signature:_____

Witness: _____

Date: _____