Connection Point Counselling and Consulting

1510 - 1 Street SE, Calgary AB, T2G 2J5
403-909-0639

Counselling Intake Form

The information contained in this form is legally protected and will remain confidential. Please take your time and answer the questions to the best of your ability.

First Name: _____ Last Name: _____

Preferred Name: _____

Home Phone: _____ Mobile Phone: _____

Is it ok to leave a voicemail? (Mobile) Yes ___ No___ (Home) Yes ___ No___

Email Address: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Date of Birth: _____ Age: _____ Gender: _____

Health Card #: _____ Province: _____

Emergency Contact: _____

Relationship: _____ Phone #: _____

Do you have any accessibility concerns? _____

Do you have extended health benefits? Yes ____ No ____

Provider: _____

Group #: _____ Member #: _____

How did you hear about us?

- ☐ Family Physician _____
- ☐ Non-Profit Agency _____
- ☐ Other Health Provider _____
- ☐ Friend _____
- ☐ Social Media _____
- ☐ www.connectionpoint.online
- ☐ Psychology Today
- ☐ Linkedin
- ☐ Other _____

My reasons for wanting therapy at this time:

_____

_____

_____

Do you have any mental health diagnosis? Yes _____ No _____

If yes, please describe:

Diagnosis	Date diagnosed	By whom?

Do you have any health problems or medical issues? Yes ____ No ____

If yes, please provide details:

_____

_____

_____

Are you taking any medication or supplements? Yes ____ No ____

If yes, please provide details as outlined below:

Medication Name	Dose (mg)	Quantity	Reason for taking?	Prescribed by?

Any history of suicidal ideation? Yes ____ No ____

If yes, please check when: ____ within 3 months ____ past year ____ more than one year ago

Any suicide attempts? Yes ____ No ____

If yes, please check when: ____ within 3 months ____ past year ____ more than one year ago

Any history of self harm? Yes ____ No ____

If yes, please check when: ____ within 3 months ____ past year ____ more than one year ago

Any history of substance use? Yes ____ No ____

If yes, please check when: ____ within 3 months ____ past year ____ more than one year ago

Please indicate the substance of choice and period of use: _____

_____

Treatment History

Type of Therapy (i.e. individual/group/residential)	When/Duration/With Whom?

Intake forms can be be returned via:

- Email to johnathan@connectionpoint.online
- In person at your initial appointment