YOUNG PERSONS COUNSELLING INTAKE FORM

Note: This information is confidential

Name:	Date:
Date of Birth:	Age/Gender:
Home Address:	
Who do you live with?:	
Home/Cell Phone:	Is it ok to leave a message for you at this number? Y / N
Email:	Is it ok to email you? Y / N
School:	Grade:
Job (if none, leave blank):	Hobbies:
Does your caregiver know you're attending counselling?:	
Do you consent for them to be part of your sessions?:	
Emergency Contact Name:	
ER Contact Relationship:	Emergency Contact Phone:
How were you referred?	

What is it you'd like our meeting to get done?

_____

THOUGHTS CHECKLIST

Please rate each area with a number:

1=Major Thought 2=Sometimes a Thought 3=Never a Thought

_____ Getting along with my peers

_____ Hard to sleep/nightmares

_____ Feeling bad about the way I look/my body

_____ Dealing with heartbreak/loss

_____ Getting along with my family

_____ No motivation/energy

_____ Feeling angry or resentful

_____ Dealing with sexual feelings and/or concerns

_____ Feeling down/sad

_____ Lots of worry or anxiety

_____ Trying to decide on a career

_____ Feeling guilty/shameful

_____ Never eating/eating too much and vomiting to control weight

_____ Dealing with my alcohol or drug use

_____ Dealing with problems at school

_____ Dealing with how I feel about myself

Are there any other concerns or areas you would like to address?

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