Julia Valley, MSW RSW

OCSWSSW Registration # 816408

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Client Intake Questionnaire

Date

Client Information

Given Name

Preferred Name

Birthdate

Sexual Orientation

Gender

Preferred Personal Pronouns

- She/ Her/ Hers
- He/ Him/ His
- They/ Them/ Theirs
- Other

Contact Information

Street Address

Street Address (Line 2)

City

Province

Postal Code

Phone Number

Save to leave message?

- Yes
- No

Email Address

Preferred method of contact?

- Phone
- Text
- Email

Name of Emergency Contact

Relation of Emergency Contact

Phone Number of Emergency Contact

Name of Primary Care Provider

Phone Number of Primary Care Provider

Name of Pharmacy

Phone Number of Pharmacy

Name of Psychiatrist

Phone Number of Psychiatrist

Name of Former Therapist

Phone Number of Former Therapist

Are you currently:

Single - Never married	Partnered	Widowed
Married	Separated	Divorced

Name and Ages of Children:

Names and Types of Pets:

Are you currently:

Studying	Unemployed	Retired
Working - Part-time	Working - Full-time	On leave
Stay-at-home caregiver	Other	

Health History

Have you ever been diagnosed with:

- Autoimmune Disorder (i.e. Inflammatory Bowel Disease, Lupus, Multiple Sclerosis, Psoriasis, Rheumatoid Arthritis)
- Cancer
- Cardiovascular Disorder (i.e. Chronic Heart Failure, High Cholesterol, Low/High Blood Pressure, Myocardial Infarction, Stroke)
- Chronic Pain
- Dermatological Disorder (i.e. Acne, Eczema, Psoriasis)
- Endocrine Disorder (i.e. Diabetes, Thyroid/ Parathyroid Issues)
- Gastrointestinal Disorder (i.e. Celiac, Crohn's/ Colitis, Gallstones, Gastric Ulcer, Inflammatory Bowel Syndrome)
- Infectious Disease (i.e. HIV, Hepatitis, Sexually Transmitted Infection)
- Mental Health Disorder
- Musculoskeletal Disorder (i.e. Arthritis, Fibromyalgia, Muscular Dystrophy, Osteoporosis)
- Neurological Disorder (i.e. Headaches/Migraines, Seizures, Multiple Sclerosis, Parkinson's)
- Respiratory Disorder (i.e. Asthma, COPD, Cystic Fibrosis)
- Substance-Related Disorder

Do you consume caffeine?

- No
- No - but I used to
- Yes - daily
- Yes - weekly
- Yes - socially

Do you consume alcohol?

- No
- No - but I used to
- Yes - daily
- Yes - weekly
- Yes - socially

Do you consume tobacco?

- No
- No - but I used to
- Yes - daily
- Yes - weekly
- Yes - socially

Do you consume marijuana?

- No
- No - but I used to
- Yes - daily
- Yes - weekly
- Yes - socially

Do you consume other recreational drugs?

- No
- No - but I used to
- Yes - daily
- Yes - weekly
- Yes - socially

Have you ever been diagnosed with?

- Anxiety Disorder
- Attention Deficit Hyperactivity Disorder
- Autism Spectrum Disorder
- Bipolar Disorder
- Depressive Disorder
- Developmental Delay
- Eating Disorder
- Obsessive-Compulsive Disorder
- Personality Disorder
- Schizophrenia
- Stress-Related Disorder (i.e. PTSD)
- Substance-Related Disorder

Please list any vitamins and supplements that you take on a regular basis:

Please list any medication(s) that you take on a regular basis:

Have you ever accessed treatment for a mental health disorder?

- No
- Yes - I have seen a therapist/ social worker/ psychologist/ psychotherapist/ counsellor
- Yes - I have seen a psychiatrist
- Yes - I have been admitted to an inpatient mental health unit
- Yes - I have participated in group therapy/ day treatment
- Other

Signs and Symptoms

Please select any signs or symptoms of emotional challenges that you have been experiencing over the past 3 months:

- Anxiety
- Body-image issues
- Compulsive behaviours
- Crying spells
- Decreased appetite
- Decreased energy
- Decreased libido
- Depressed mood
- Difficulty concentrating
- Engaging in risk-taking behaviours
- Engaging in self-harming behaviours
- Excessive worrying
- Fatigue
- Feelings of guilt
- Feelings of helplessness
- Feelings of hopelessness
- Hallucinations
- Impulsivity
- Increased appetite
- Increased energy
- Increased libido
- Intrusive/ ruminating thoughts
- Loss of interest in activities
- Loss of memory
- Low self-esteem
- Obsessive thoughts
- Overeating
- Overuse of alcohol
- Overuse of gambling
- Overuse of sex
- Overuse of shopping
- Panic attacks
- Purging (i.e. use of laxatives, vomiting)
- Racing thoughts
- Relationship problems
- Restricting food intake
- Self-injury (i.e. cutting, self-hitting)
- Sleep disturbances
- Social withdrawal
- Suspiciousness
- Thoughts of hurting someone else
- Thoughts of suicide

Have you ever engaged in eating disordered behaviours?

- No
- Yes - I have restricted my food intake
- Yes - I have exercised excessively
- Yes - I have taken diuretics and/or laxatives
- Yes - I have made myself vomit
- Yes - I have used stimulant drugs
- If 'yes', when was the most recent time?

Have you ever engaged in self-injurious behaviours?

- No
- Yes - (i.e. I have cut/ burned/ hit myself)
- If 'yes', when was the most recent time?

Have you ever had thoughts of suicide, and have you ever acted on these thoughts?

- No
- Yes - I have had them in the past, but I have never acted on them
- Yes - I have had them in the past, and I did act on them
- Yes - I have them now, but I do not think I would act on them
- Yes - I have them now, and I may act on them
- If 'yes', when was the most recent time?

Have you ever had thoughts of hurting someone else, and have you ever acted on these thoughts?

- No
- Yes - I have had them in the past, but I have never acted on them
- Yes - I have had them in the past, and I did act on them
- Yes - I have them now, but I do not think I would act on them
- Yes - I have them now, and I may act on them
- If 'yes', when was the most recent time?

What concerns/ issues would you like to address in therapy?

Why have you decided to access therapy now?

Is there anything else you would like your therapist to know about you?

How did you hear about our services?

- Online search
- Facebook
- Psychology Today
- TherapyOwl
- Referral from a friend/ family member)
- Referral from a professional

If referred, please tell us by who: