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Psychotherapy and TAP (Tapping Assisted Psychotherapy)

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OCSWSSW REG'N #324645

INTAKE INFORMATION

The information you provide here is protected as confidential information.

There are two sections to this form. Section I is information I collect routinely for all new clients. ***Section II gives you the option of providing additional information if you would like me to have this information about you at this time.***

SECTION I

Date: _____

Name: _____
(Last) (First)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____
dd *mm* *yyyy*

Address: _____
(Street and Number) (Unit)

_____
(City) (Province) (Postal Code)

Primary Phone: ( ) _____ May I leave a message at this number? □ Yes □ No May I text you at this number? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No

Referred by (if any): _____

Marital Status:

□ Never Married □ Living Together □ Married □ Separated □ Divorced □ Widowed

Partner or spouse's first name, if applicable: _____

Please list any children/age(s): _____

_____

Are you currently employed or in school? □ Yes □ No

Please describe: _____

What would you like to accomplish out of your time in therapy? Please feel free to describe this in as much or as little detail as you wish. If you have specific goals that you would like to work on in your therapy, you can list them here if you wish.

_____
_____
_____
_____
_____
_____
_____
_____
_____

What do you, or others, consider to be some of your strengths?

_____
_____
_____

Are there any barriers that could affect your ability to accomplish your therapeutic goals?

_____
_____

Thank you for completing Section I of this Intake Form.

SECTION II (OPTIONAL)

Please complete *any or all* of the following questions if you would like me to have this information about you. The information is protected as confidential.

Are you currently receiving any psychotherapy services? □ Yes □ No

If yes, please describe briefly: _____

_____

If you are currently taking any medications, please list names and dosages. Include over-the-counter medications and supplements: □ N/A

_____

_____

_____

Have you ever been given a mental health diagnosis (for example: "depression", "bipolar disorder" or "OCD")? □ Yes □ No

If yes, please describe briefly: _____

_____

How would you rate your current physical/medical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please briefly list/describe any current or past significant medical illnesses or problems:

_____

_____

_____

How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please describe any specific sleep problems you are currently experiencing:

_____

_____

Please describe any significant current difficulties you are experiencing with your appetite or eating patterns: □ N/A

_____

_____

Are you currently experiencing significant sadness or grief? □ Yes □ No

If yes, for approximately how long? _____

Are you currently experiencing significant anxiety or panic attacks? □ Yes □ No

If yes, please describe briefly: _____

_____

Are you currently experiencing chronic pain? □ Yes □ No

If yes, please describe briefly: _____

_____

Are you, or are others close to you, concerned about your use of substances such as alcohol, marijuana, etc.? □ Yes □ No

If yes, please describe briefly: _____

_____

What significant life changes or stressful events have you experienced recently, if any?

_____

_____

_____

Is there anything else you would like to share about yourself at this time?

_____

_____

Thank you for completing Section II of this Intake Form.