Carolyn Higginson MSW,RSW

New Client Intake Form

The information requested is necessary to better understand your counselling goals. Please be assured that all information submitted will be kept confidential. Your health information is private.

Client Information

First Name _____ Last Name _____

Address _____ Postal Code _____

Phone - Home _____ Work _____ Ext. _____ Cell _____

E-mail _____

Current Status (married, divorced, separated, etc.)

_____

Referred by _____

*Employment: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired

☐ On Leave ☐ Student ☐ Self-Employed

Occupation _____

Would you prefer that your counsellor contact you by: ☐ Phone ☐ Email ☐ No Preference

If you prefer to be contacted by phone, for reasons of confidentiality, please advise us if we can contact you and/or leave a message at the numbers you have provided.

	Yes	No
HOME	☐	☐
WORK	☐	☐
CELL	☐	☐

*Request for: ☐ Individual Therapy ☐ Couple Therapy

18 Spencer Street E., Cobourg, Ontario
(905) 372-2369 | info@carolynhigginson.com
www.carolynhigginson.com

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Counselling History

Personal Physician _____

Medication _____

Previous Therapy (e.g. Social Workers, Psychologists, Children's Aid Society, Psychiatrists)

_____

_____

In case of an emergency who should be contacted? Name _____

Phone Number _____ Relation to You _____

Do you have extended health care (EHC)? ☐ YES ☐ NO

Insurance Company _____

Are social work services covered under your EHC plan? ☐ YES ☐ NO

Benefit Limitation _____

***Presenting Issues** (Check all that apply)

☐ Addiction	☐ Anger Management	☐ Anxiety	☐ Emotion Regulation
☐ Career & Work Related	☐ Health Related	☐ Co-Parent Counselling	☐ Couples & Relationships
☐ Depression	☐ Family	☐ Grief	☐ Life Transition
☐ Separation & Divorce	☐ Stress		

Please provide a brief description of presenting issue: _____

_____

_____

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What are you hoping to see change as a result of counselling? _____

_____

_____

_____

Are there any potential barriers to treatment (i.e. work schedule)? _____

_____

_____

_____

Office Use Only

Fees Quoted _____

Initial Appopintment Date _____

Medication _____

Counsellor Notes _____

_____

_____

I have read, understood and completed this questionnaire with accuracy and to the best of my knowledge. Any questions I had were answered to my satisfaction.

Name of Client(s): _____

_____ _____

Witness Name

_____ _____

Client's Signature Date

_____ _____

Second Client's Signature Date

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