Kodi Graham, MSW, RSW
Clinical Therapist

# 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 _____ Date of Birth _____

Address _____ Postal Code _____

Phone – Home _____ Work _____ Ext. _____ Cell _____

E-mail _____

Referred by _____

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

Current Custody Status (if applicable) _____

Employment Status □ Full-time □ Part-time □ Unemployed □ On Leave

□ Student □ Self-Employed □ Retired

School Name _____ Grade_____

Preferred method of contact: □ Phone □ E-mail □ No Preference

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

Home: □ Yes □ No Work: □ Yes □ No Cell: □ Yes □ No

## Counselling History

Physician Name _____

Medication _____

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

_____

_____

Have you received services from Kinark Child and Family Services within the last 2 years? □ Yes □ No

If no, are you on the waitlist to receive services from Kinark Child and Family Services? □ Yes □ No

In case of an emergency, who should we contact? Name _____

Phone Number _____ Relationship _____

18 Spencer Street E., Cobourg, Ontario
(905) 372-2369| info@nurturinghealth.ca
www.facebook.com/kodigrahammsw/

Kodi Graham, MSW, RSW
Clinical Therapist

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)

| | | |
|---|---|---|
| □ Parenting | □ Anger Management | □ Anxiety |
| □ Emotion Regulation | □ Addiction | □ Health Related |
| □ Depression | □ Family | □ Focus and Attention |
| □ Grief | □ Stress | □ Survivor of Violence |

Please provide a brief description of presenting issue:

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

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.

Client Signature (if over 12): _____ Date: _____

Parent Signature: _____ Date: _____

Second Parent Signature: _____ Date: _____

Witness Signature: _____ Date: _____

18 Spencer Street E., Cobourg, Ontario
(905) 372-2369| info@nurturinghealth.ca
www.facebook.com/kodigrahammsw/

**Office Use Only**

Fees Quoted _____

Initial Appointment Date _____

Counsellor Notes _____

_____

_____

18 Spencer Street E., Cobourg, Ontario
(905) 372-2369| info@nurturinghealth.ca
www.facebook.com/kodigrahammsw/