



Margarida Medeiros, BSW(Hons),RSW

New Client Intake Form: The information requested is necessary to better understand your counselling goals. The information submitted is kept strictly confidential. Your health information is private.

Client Information

First Name _____ Last Name _____

Address _____ Postal Code _____

Phone(Home) _____ Work _____ Ext. ____ Cell _____

Email _____

Current status (married, divorced, separated, single etc.)

Referred by _____

Employment:

___ Full-time ___ Part-time ___ Unemployed ___ Retired

___ On leave ___ Student ___ Self-employed

Occupation _____

Contact preference to maintain confidentiality:

___ Cell ___ Home Phone ___ Work Phone ___ Email ___ No preference

SERVICE REQUESTED: ___ Individual Therapy ___ Couple Therapy

18 Spencer St. E., Cobourg, Ontario/(905) 372-2369
info@nurturinghealth.ca



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Counselling and Other Interventions Received

Personal Physician _____

Medication _____

Previous Interventions/Resources Accessed (eg. Social Workers, Psychologists, Psychiatrists, Children’s Aid)

In case of emergency who should be contacted? Name _____

Phone Number _____ Relation to You _____

Do you have extended health care (EHC)? Yes No

Are social work services covered under your EHC plan? Yes No

Benefit Limitation _____

Presenting Issues (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Anger Management | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Career Work Related | <input type="checkbox"/> Co-Parent Counselling | <input type="checkbox"/> Couples/Relationship |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Emotions (managing them) | <input type="checkbox"/> Family |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Health Related | <input type="checkbox"/> Life Transition |
| <input type="checkbox"/> Separation and Divorce | <input type="checkbox"/> Stress | |

Please provide a brief description of the presenting concern(s): _____

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What changes would you most like to see as a result of participating in counselling?_____

Is there anything that might make it difficult to participate in counselling at this time (i.e. work schedule)?

Office Use Only

Fees Quoted _____

Initial Appointment Date_____

Medication_____

Counsellor Notes_____

I have read, understood, and completed this questionnaire with accuracy and to the best of my knowledge. I am satisfied with the information I was provided about the process and any questions I had were answered to my satisfaction.

Name of Client(s) _____

Witness Name _____ Date_____

Client Signature _____ Date_____

Client Signature _____ Date _____