INTAKE QUESTIONNAIRE

Name:_____

Address:_____

_____

_____email_____

Phone: _____

Gender:_____Marital Status:_____

Occupation:_____

Presenting Issues or reasons for current consultation:

_____

_____

_____

_____

_____

_____

_____

Ethnic/Racial/Religious Background:_____

Sibling's names and ages:_____

_____

Brief description of relationship with mother:

_____

_____

_____

_____

Brief description of relationship with father:

_____

_____

_____

_____

Brief description of relationships with siblings:

_____

_____

_____

_____

Relationship Status:_____

Brief description of current relationship:

_____

_____

_____

_____

_____

Brief Relationship History:

_____

_____

_____

_____

_____

Children's names and ages:_____

_____

Brief description of relationship with children:

_____

_____

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_____

Brief Description of past counselling, self-awareness, and/or growth work:

_____

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_____

Have you ever been sexually, physically, emotionally or verbally abused? _____

Brief description of abuse or bullying:

_____

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_____

STEPPING STONES: Now name **KEY** events that stand out in each decade of your life. These include challenges, medical crises, traumas, deaths, losses, defeats and successes, achievements, victories, in any arena--school, work, sports, relationships, creative endeavours, spiritual awareness, community activities.

Birth--Age 10:

_____

_____

_____

_____

10--20 yrs:

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_____

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_____

20-30 yrs:

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_____

30--40 yrs.

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_____

40--50 yrs:

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_____

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_____

50--60 yrs:

_____

_____

_____

_____

60--70 yrs:

_____

_____

_____

_____

70--present time:

_____

_____

_____

_____

LIFESTYLE :

Height:_____ Weight:_____

Sleep Pattern: (quality, what time you go to sleep and awaken, regularity or irregularity of sleep schedule, ease or difficulty of falling and staying asleep)

_____

_____

_____

_____

Routine napping:_____

Exercise: (stretching, aerobic, weight training, specific sports, dance, yoga, etc.)

_____

_____

_____

_____

Amount of time spent outdoors daily:_____

Air Quality: indoor and outdoor where you reside:

_____

_____

_____

_____

Water consumption: (Distilled, bottled spring water, filter system, tap),

_____

_____

NUTRITION:

Describe a typical week. Include every meal, snacks, intervals between eating, quantities consumed, time allotted to each meal, who else is present and nature of interaction, description of spices, herbs, condiments, sauces, ingredients if consuming canned, packaged, frozen or otherwise processed foods and liquids.

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Past or present eating disorders:

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Past or present substance use/abuse: (alcohol, drugs, caffeine, chocolate, sugar, prescription drugs, vitamins, herbal remedies)

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Past or present medical illnesses, diseases, challenges:

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_____

Brief summary of prior medical and health consultations

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_____

_____

_____

Brief summary of current or past financial stresses or successes:

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_____

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_____

Other IMPORTANT information:

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_____

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