Dr. Steve G. Conway Counselling & Psychotherapy

STEVE G. CONWAY, Psy.D, RCC
Registered Clinical Counsellor (Reg. 2313)

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Intake Form

Name:____
Date of Birth:____________________________________

Address:____

Phone: (H):____________(C):____________(w):____________
Email Adress:____________________________________

Emergency Contact Name:________________Phone:____________

Occupation / Employer:______________________________

Level of Education:________________________________

Reason for seeking counselling:________________________

How did you find out about this service?____________________

Previous counselling / treatment – please describe:________________

Describe current stressors (Emotional, relationship, financial, career, health, other):

Relationships - Please describe: (Married or single? Do you live alone? Children? Social support system?

Mental health (current or previous diagnosis for mental health condition, family history):

How are you sleeping?
Changes in appetite / weight gain or loss?
Memory / concetration:
Describe your mood – how you have been feeling lately:

Are you feeling isolation or loneliness?

Are you feeling suicidal – do you feel like killing / harming yourself?

Previous suicide attempts – thoughts of suicide:

Medical health concerns (current or previous physical health problems, chronic conditions):

Medications for physical / mental health concerns (please describe current or past):

Name of Physician (G.P) and contact information (address / phone number):

Last appointment with physician:

Describe use of alcohol & drugs (substance, amount used, frequency, duration):_______

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Do you exercise (what and how often)?____
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What are your hobbies & interests?____
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Comments:____
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