SHANE SMYTH PSYCHOTHERAPY
INTAKE FORM

ALL INFORMATION YOU ARE PROVIDING IS STRICTLY CONFIDENTIAL

CONTACT INFORMATION

NAME_____ **DATE**_____

ADDRESS _____ POSTAL CODE _____

HOME PHONE _____ CELL _____ WORK _____

EMAIL_____

- ✓ **PLEASE INDICATE WITH A CHECK MARK AT WHICH NUMBER(S)/MAIL WE MAY LEAVE MESSAGES**
- ✓ **IS IT OKAY TO USE YOUR EMAIL ADDRESS TO CONTACT YOU? NO_____ YES _____**

PERSONAL INFORMATION

EMPLOYER _____ POSITION _____

MARITAL STATUS _____ CHILDREN (names/ages) _____

_____

BIRTH DATE _____ AGE _____

MEDICAL/PSYCH HISTORY

RELEVANT MEDICAL ISSUES _____

CURRENT MEDICATIONS & DOSAGES _____

FOR HOW LONG? _____

Family Physician _____ Phone _____

Have you had previous counselling/therapy? NO _____ YES _____

If YES, for what period of time? _____

How long ago? _____

What was the result? (*i.e., very helpful, not helpful, "didn't work", etc.)* _____

Are you here for the same issue? NO _____ YES _____ MAYBE _____

EMERGENCY CONTACT

Person to contact in an emergency _____

Phone number(s) _____Relationship _____