Mending Minds, Healing Hearts
gentlecurrentstherapy.com

INTAKE QUESTIONNAIRE

(Last Name) (First Name) (Middle Name)

Gender Identification: _____ **Date of Birth: (D)** _____ **(M)** _____ **(Y)** _____

Preferred Gender Pronouns (Please circle): He/His She/Hers They/Theirs Other: _____

Marital Status: Single ( ) Married ( ) Common Law ( ) Separated ( ) Divorced ( ) Widowed ( )

(Street Address)

(City) (Province) (Postal Code)

(Cell Phone) (Home Phone) (Work Phone)

(Email Address) *Note:* ***All invoices and receipts are emailed. Please ensure the email address you provide is the one you want these documents sent to.***

Referred by: _____

We can send **email confirmations** of new appointments and changes. Please choose one of the following:

☐ I consent to receiving email confirmations of new appointments and changes.
☐ I do not wish to receive email confirmations of new appointments and changes and will keep track myself.

We can also send **text and/or email reminders 72 hours ahead** of upcoming appointments. Please choose from the following options:

☐ I consent to receiving a reminder 72 hours prior to my scheduled appointment by (check all that apply):

☐ SMS Text Message. Send to **<u>one</u>** of: ☐ Cell Phone ☐ Home Phone ☐ Work Phone
☐ My preferred email address listed above.

☐ I do not wish to receive appointment reminders. I understand that I am responsible for remembering my appointment date and time. I am aware that if I cancel, change, or miss an appointment with less than 48 hours notice that I will be charged a cancellation fee equivalent to the full session fee.

We can also send emails to let people know of **upcoming groups or events** at Gentle Currents. Please choose one of the following:

Turn page →

Briefly answer the following questions:

1. State in your own words the nature of your main concerns (Please indicate the duration)

2. What have you done about these concerns to date?

3. List what benefits you hope to receive from counselling:

4) What is there about your present behaviours that you would like to change?

5) What feelings would you like to change (e.g. increase or decrease)?

6) What thoughts would you like to change?

List previous counselling or other treatment for personal and/or marital problems:

Dates: Type of problem: Name of professional or agency:

FOLLOW-UP AUTHORIZATION

Would you be willing to be contacted regarding the services you received? Yes ( ) No ( )

Client signature **Date**