Client Intake Form

Please complete before your first session. Everything you share is confidential within the limits your therapist explains in section 8. Practice: _____ Therapist: _____

1. Client Information

Legal name: _____ Name you go by: _____

Pronouns (optional): _____ Date of birth: _____

Address (street, city, state/province, ZIP/postal code):

_____

Phone: _____ May we leave a voicemail at this number? ☐ Yes ☐ No

Email: _____ May we email you? (see section 8) ☐ Yes ☐ No

Preferred language for services and documents: ☐ English ☐ Français ☐ Other: _____

Family physician or nurse practitioner (name and clinic, optional): _____

How did you hear about us? _____

Accessibility needs or accommodations that would help you participate:

_____

2. Emergency Contact and Safety

Emergency contact: name _____ relationship _____ phone _____

Is there anything we should know to contact you safely? (e.g., a shared phone or household, messages you would prefer we not leave)

_____

3. Presenting Concerns and Goals

What brings you to counseling now? (a few sentences is plenty)

_____

_____

How long has this been a concern? _____

Areas of life affected: ☐ Mood ☐ Anxiety or stress ☐ Relationships ☐ Work or school ☐ Sleep ☐ Grief or loss ☐ Trauma ☐ Substance use ☐ Other: _____

In the past month, have you had thoughts of harming yourself or ending your life? ☐ Yes ☐ No ☐ Prefer to discuss in session

A "yes" means we will talk about it together; it does not trigger anything automatic.

What would success in counseling look like for you?

_____

What have you already tried? (previous strategies, self-help, other supports)

_____

4. Health and Medications

Current medical conditions or recent hospitalizations:

Current medications (name • dose • prescriber), including psychiatric medications:

Past psychiatric medications, if any:

Sleep: typical hours and any difficulties: _____

Substance use (frequency, in your own words): alcohol _____ cannabis _____ nicotine _____ caffeine _____ other _____

5. Mental Health History

Previous counseling or therapy (approximate dates, and what helped or didn't):

Previous diagnoses, as you understand them:

Any psychiatric hospitalizations: _____

Any history of self-harm or suicide attempts: _____

Significant losses or experiences you consider traumatic (a yes/no or a short phrase is enough; you set the pace on what we explore, and when):

6. Family and Social Context

Who is in your household? _____

Relationship status: _____ Children, if any: _____

Work, school, or other daily structure: _____

People or communities you can lean on: _____

Cultural, spiritual, or religious practices you'd like reflected in your care:

Family history of mental health concerns (brief):

7. Insurance and Payment

Complete the block that applies. Private-pay clients: skip to the fee acknowledgment your therapist provides.

United States

Insurer: □ Aetna □ Cigna □ UnitedHealthcare □ BCBS □ Anthem □ Humana □ Optum □ Other: _____

Member ID: _____ Group #: _____

Plan holder (if not you): name _____ DOB _____

Relationship to plan holder: □ Self □ Spouse □ Dependent

Secondary coverage (insurer + numbers):

Canada

Insurer: □ Sun Life □ Manulife □ Canada Life □ Desjardins □ Green Shield □ Blue Cross □ Other: _____

Policy / group #: _____ Member ID: _____

Plan member (if not you): name _____ DOB _____

Relationship to plan member: □ Member □ Spouse □ Dependant

Third-party payer, if any (WSIB / auto insurer / VAC): claim # _____

□ I consent to my therapist billing my insurer directly on my behalf, where offered. Does your plan cover services by your therapist's license type? □ Yes □ No □ Will confirm

8. Consent and Acknowledgements

Model language; your therapist will review each item with you. US practices: this accompanies the HIPAA privacy-notice acknowledgment. Canadian practices: this consent reflects PHIPA, PIPEDA, or Quebec's Loi 25, as applicable.

□ **Consent to services and information collection.** I consent to receive counseling services and to my therapist collecting and using the information on this form to provide care, keep required records, and communicate with me as agreed below.

□ **Confidentiality and its limits.** I understand my information is confidential, with limited exceptions my therapist has explained (risk of serious harm to myself or others, suspected abuse or neglect of a child or vulnerable person, court orders, and regulatory audits).

□ **Electronic communication.** I consent to receive appointment reminders, documents, and invoices by email at the address above. I understand that ordinary email is not fully secure, and that I may withdraw this consent at any time. My therapist □ may □ may not leave voicemail at the number above.

□ **Virtual sessions (if applicable).** I consent to sessions by secure video where clinically appropriate. I understand the practical limits of virtual care (technology failures, privacy on my end of the call) and that my therapist will confirm my location at the start of each virtual session in case of emergency.

□ **Session recording and AI-assisted documentation (if applicable).** I consent to my sessions being recorded for documentation purposes. Tool: _____. The tool transcribes the session so that my therapist can prepare the clinical note; my therapist reviews every note before it enters my record. Audio is deleted on this schedule: _____. I may decline or withdraw this consent at any time without affecting my care.

□ **Privacy notice.** I acknowledge that I have received and had the chance to review the practice's privacy notice.

Client signature	Date
Parent / guardian signature (if applicable; see your jurisdiction's minor-consent rules)	Date
Therapist signature	Date