TRUE LIVING
COUNSELLING

Adult Intake Form

Gita Ward, BA, MSW, RCSW
WWW.TrueLivingCounselling.com
Truelivingcounselling@gmail.com
(587) 896-6919
#240 158 Southbank St.
Okotoks, AB. T1S 0R5

Name First:	**Last:**
Street Address:	**Date of Birth:**
City, Province, Postal Code:	**Home Phone (Message?):**
Email Address:	**Mobile Phone (Message?):**
Primary Physician:	**Psychiatrist (if any):**
Emergency Contact Person:	**Emergency Contact Phone:**
How did you hear about us?	**Marital Status:**

Mental Health Diagnosis:	**Medications:**
Physical Health Concerns:	**Medications:**
Current Reason for Seeking Counselling:	**Other Important Information:**

Client Questionnaire

Are you in school/studying? If so, what are you studying? Where? Which year are you in?

_____

_____

Occupation: _____ How Long?_____
Place of Employment: _____
How Long?_____ City: _____

If not employed, how long has it been since you worked?_____
What kind of job did you have? _____
What caused you to stop working?_____

Have you ever been or are you now in the military? Yes / No If yes please describe.

PERSONAL STRENGTHS What activities do you enjoy and feel you are successful when you try?

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) _____

_____

What would you like to see happen as a result of counselling? _____

_____

COUNSELLING HISTORY

Have you previously seen a counselor? If yes, what did you find most helpful in therapy?

_____

_____

If yes, what did you find least helpful in therapy? _____

_____

ANYTHING ELSE YOU WOULD LIKE TO SHARE

_____

_____

Beck's Depression Inventory

Please answer the best descriptor of how you have been feeling the past 7 days

1.	0	I do not feel sad
	1	I feel sad
	2	I am sad all the time and I can't snap out of it
	3	I am so sad and unhappy that I can't stand it
2.	0	I am not particularly discouraged about the future
	1	I feel discouraged about the future
	2	I feel I have nothing to look forward to
	3	I feel the future is hopeless and that things cannot improve
3.	0	I do not feel like a failure
	1	I feel I have failed more than the average person
	2	As I look back on my life, all I can see is a lot of failures
	3	I feel I am a complete failure as a person
4.	0	I get as much satisfaction out of things as I used to
	1	I don't enjoy things the way I used to
	2	I don't get real satisfaction out of anything anymore
	3	I am dissatisfied or bored with everything
5.	0	I don't feel particularly guilty
	1	I feel guilty a good part of the time
	2	I feel quite guilty most of the time
	3	I feel guilty all of the time
6.	0	I don't feel I am being punished
	1	I feel I may be punished
	2	I expect to be punished
	3	I feel I am being punished
7.	0	I don't feel disappointed in myself
	1	I am disappointed in myself
	2	I am disgusted with myself
	3	I hate myself
8.	0	I don't feel I am any worse than anybody else
	1	I am critical of myself for my weaknesses or mistakes
	2	I blame myself all the time for my faults
	3	I blame myself for everything bad that happens
9.	0	I don't have any thoughts of killing myself
	1	I have thoughts of killing myself, but I would not carry them out
	2	I would like to kill myself
	3	I would kill myself if I had the chance

10.	0	I don't cry any more than usual
	1	I cry more now than I used to
	2	I cry all the time now
	3	I used to be able to cry, but now I can't cry even though I want to
11.	0	I am no more irritated by things than I ever was
	1	I am slightly more irritated now than usual
	2	I am quite annoyed or irritated a good deal of the time
	3	I feel irritated all the time
12.	0	I have not lost interest in other people
	1	I am less interested in other people than I used to be
	2	I have lost most of my interest in other people
	3	I have lost all of my interest in other people
13.	0	I make decisions about as well as I ever could
	1	I put off making decisions more than I used to
	2	I have greater difficulty in making decisions more than I used to
	3	I can't make decisions at all anymore
14.	0	I don't feel that I look any worse than I used to
	1	I am worried that I am looking old or unattractive
	2	I feel there are permanent changes in my appearance that make me look unattractive
	3	I believe that I look ugly
15.	0	I can work about as well as before
	1	It takes an extra effort to get started at doing something
	2	I have to push myself very hard to do anything
	3	I can't do any work at all
16.	0	I can sleep as well as usual
	1	I don't sleep as well as I used to
	2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
	3	I wake up several hours earlier than I used to and cannot get back to sleep.
17.	0	I don't get more tired than usual
	1	I get tired more easily than I used to
	2	I get tired from doing almost anything
	3	I am too tired to do anything
18.	0	My appetite is no worse than usual
	1	My appetite is not as good as it used to be
	2	My appetite is much worse now
	3	I have no appetite at all anymore
19.	0	I haven't lost much weight, if any, lately
	1	I have lost more than five pounds

	2	I have lost more than ten pounds
	3	I have lost more than fifteen pounds
20.	0	I am no more worried about my health than usual
	1	I am worried about physical problems like aches, pains, upset stomach, or constipation
	2	I am very worried about physical problems and it's hard to think of much else
	3	I am so worried about my physical problems that I cannot think of anything else
21.	0	I have not noticed any recent change in my interest in sex
	1	I am less interested in sex than I used to be
	2	I have almost no interest in sex
	3	I have lost interest in sex completely

Total Score:_____ Date: _____

How was I feeling at this time?:_____

The Burns Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the **past week**, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Somewhat	Moderate	A Lot
Category I: Anxious Feelings				
1. Anxiety, nervousness, worry, or fear	0	1	2	3
2. Feeling that things around you are strange, unreal or foggy	0	1	2	3
3. Feeling detached from all or part of your body	0	1	2	3
4. Sudden unexpected panic spells	0	1	2	3
5. Apprehension or a sense of impending doom	0	1	2	3
6. Feeling tense, stressed, “uptight”, or on edge	0	1	2	3
Category II: Anxious Thoughts				
7. Difficulty concentrating	0	1	2	3
8. Racing thoughts or having your mind jump from one thing to the next	0	1	2	3
9. Frightening fantasies or daydreams	0	1	2	3
10. Feeling that you’re on the verge of losing control	0	1	2	3
11. Fears of cracking up or going crazy	0	1	2	3

12. Fears of fainting or passing out	0	1	2	3
13. Fears of physical illnesses or heart attacks or dying	0	1	2	3
14. Concerns about looking foolish or inadequate in front of others	0	1	2	3
15. Fears of being alone, isolated, or abandoned	0	1	2	3
16. Fears of criticism or disapproval	0	1	2	3
17. Fears that something terrible is about to happen	0	1	2	3
Category III: Physical Symptoms				
18. Skipping or racing or pounding of the heart (sometimes called "palpitations")	0	1	2	3
19. Pain, pressure, or tightness in the chest	0	1	2	3
20. Tingling or numbness in the tows or fingers	0	1	2	3
21. Butterflies or discomfort in the stomach	0	1	2	3
22. Constipation or diarrhea	0	1	2	3
23. Restlessness or jumpiness	0	1	2	3
24. Tight, tense muscles	0	1	2	3
25. Sweating not brought on by heat	0	1	2	3
26. A lump in the throat	0	1	2	3
27. Trembling or shaking	0	1	2	3
28. Rubbery or |"jelly" legs	0	1	2	3
29. Feeling dizzy, lightheaded, or off balance	0	1	2	3
30. Chocking or smothering sensations or difficulty breathing	0	1	2	3
31. Headaches or pain in the neck or back	0	1	2	3
32. Feeling tired, weak or easily exhausted	0	1	2	3
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here _____ .

Date: _____

How you felt at this time:_____

The Burns Anxiety Inventory is taken from *The Feeling Good Handbook, by David Burns, M.D.*

INDIVIDUAL CONCERNS: PLEASE CHECK EACH SYMPTOM YOU HAVE EXPERIENCED IN THE **PAST MONTH**- NONE, MILD, MODERATE, SEVERE

SYMPTOMS	**None**	**Mild**	**Moderate**	**Severe**	**SYMPTOMS**	**None**	**Mild**	**Moderate**	**Severe**
HOPELESSNESS					DRUG USE				
NIGHTMARES					LOW SELF WORTH				
HYPERACTIVITY					OBSESSIVE THOUGHTS				
GUILT					ANGER ISSUES				
CRYING					LONELINESS				
SUICIDAL THOUGHTS					GRIEF				
SLEEP DISTRUBANCES					PROBLEMS AT HOME				
PARANOID THOUGHTS					SOCIAL ISOLATION				
BINGING/PURGING					IMPULSIVITY				
EXCESSIVE WORRRY					PHOBIAS				
PAST SUICIDE ATTEMPTS					SELF-HARM (cutting, burning)				
ANOREXIA					GAMBLING				
HALLUCINATIONS									
WORK ISSUES					ALCOHOL USE				
FLASHBACKS					EASILY DISTRACTED				