Making the Links Intake Form

CONTACT INFORMATION

Full Name:	Date of Birth (dd/mm/yyyy):		Gender:
Street Address:	City:	Province:	Postal Code:
Telephone:	Can we leave a voice message? □ YES □ NO		
E-mail:	Would you like an e-mail reminder for your appointments? □ YES □ NO		

EMERGENCY CONTACT INFORMATION

In case of an emergency, please notify:	Telephone:
Relationship to you:	

HEALTH HISTORY

Have you ever been diagnosed with anything (e.g. medical, mental health, developmental, etc.)

□ YES □ NO

If yes, please include the following information - name of diagnosis, date of onset, treatment, ongoing/resolved:

Have you ever been hospitalized (e.g. surgery, addictions, eating disorder, self-harm, etc.) ?

□ YES □ NO

If yes, please include the reason (s) and date (s):

Are you currently taking any medications?

□ YES □ NO

If yes, please include the names, purpose and frequency:

Have you had any prior experience with therapy or counseling of any kind?

□ YES □ NO

□ If yes**,** please include the name of the therapist/agency, and number of sessions:

SOCIAL HISTORY

Living arrangement:	□ Alone	□ Family	□ Partner	□ Roommate	□ Shelter/ Couch surfing	□ Other:
Relationship Status:	□ Common Law	□ Married	□ Partnered	□ Single	□ Widowed	□ Other:
Social Supports:	□ Family	□ Friend(s)	□ Interest Group:	□ Pet (s)	□ Religious/Spiritual Affiliation:	□ Other:

EDUCATION & EMPLOYMENT

Are you currently in school? □ YES □ NO

If yes, what are you studying? _____

Are you currently employed? □ YES □ NO □ Retired □ OW □ ODSP

If yes, what is your occupation? _____

Is it: □ Full-time □ Part-time

RISK ASSESSMENT

Do you have thoughts about harming yourself?
□ YES □ NO

Do you have a plan to harm yourself?
□ YES □ NO
If yes, what is it?

Do you have thoughts about harming someone else?
□ YES □ NO

Do you have a plan to harm someone else?
□ YES □ NO
If yes, what is it?

REASONS FOR COUNSELLING

What circumstance(s) or event(s) caused you to seek counselling at this time?

Please list issues to discuss in counselling which are of primary concern:

□ Aging
□ Anger Management
□ Anxiety
□ Body Image Issues
□ Depression/Sadness
□ Grief
□ Guilt
□ Eating Difficulties
□ Loneliness/Social Isolation
□ Self-esteem
□ Shame
□ Substance Use
□ History of Trauma
□ Other: _____

□ Childhood Abuse
□ Family Issues
□ Partner Abuse/Violence
□ Relationship Issues
□ Sexual Assault/Abuse

□ Acceptance of Diagnosis
□ Hookup App/Social Media Compulsion
□ Barebacking/Condomless Sex
□ HIV-specific Anxiety
□ Negotiating Safer Sex
□ Sexual Difficulties
□ Sexual Compulsion
□ STI 101

□ Ableism
□ Coming Out Issues
□ Gender Identity Issues
□ Homophobia
□ Racism
□ Stigma/Discrimination
□ Transphobia

□ Drug Coverage
□ Education Issues
□ Employment Issues
□ Housing Issues
□ Immigration/Settlement Issues
□ Socioeconomic concerns

Please list up to three goals that you want to achieve in counselling:

1. _____
2. _____
3. _____

Date: _____ **Signature:** _____