Gateway to Change
Dispute Resolution Services

Intake Questionnaire

This intake is for the purposes of clinical assessment, and screening. Please answer all questions honestly, to the best of your ability.

General Information:

Date: _____

Last Name: _____

First Name:_____

Email: _____

Address: _____

Phone Number: _____

Preferred Method of Communication: _____

Referred by: _____

Occupation: _____

Date of Birth:_____

Place of Birth: _____

# of Years in Canada: _____

Marital Status:_____

Health Information:

List all the people who reside in the household:

_____

_____

_____

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Do you have any diagnoses (physical, special needs, mental health….etc.)

_____
_____
_____
_____

Do you take any prescribed medication? For what purpose?

_____
_____

Have you ever attended substance use counselling? Y/N

Have you or ever struggled with substances? Y/N

How many alcoholic beverages would you estimate you have per week? _____

Have you had history of depression/anxiety/mental health concerns? Y/N

If yes, please describe

_____
_____

Any attempts/thoughts/or stated intention to self-harm? Y/N

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General Information:

Do you have any religious affiliation? Describe?

_____
_____
_____

What does a normal daily routine look like for you?_____
_____
_____
_____
_____

What is going well?

_____
_____
_____
_____
_____

What would you describe as the biggest concern for you?

_____
_____
_____
_____
_____

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Trauma and Life Events Information:

Below is a list of traumatic experiences and concerns that some have experienced. Please circle which apply to your experience?

Mental Health	Hospitalizations	Surgeries	Separation of parents
Depression	Witnessing violence	Accidents	Bedwetting
Anxiety	Regressive Behaviours	Aggression	Self-Harming
Significant Loss	Sexual Abuse	Physical Abuse	Emotional Abuse
Fire Setting	Mood Swings	Irritability	Sleep Issues
Sexual Behaviours	Truancy	Learning Challenges	Disorganization
Bullying	Harming Animals	Questioning Gender Identity	
Being Bullied	Questioning Sexuality	Low Self-esteem	Memory Issues
Substance use	Running Away	Disordered Eating	

Other:

_____

_____

Major Life Events (Positive or Negative)

_____

_____

_____

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Any incidents of verbal or emotional abuse in the past six months? Y/N

At any time? Y/N

Describe:

_____
_____
_____

Any incidents of physical abuse or violence in the past six months? Y/N

At any time? Y/N

Describe:

_____
_____
_____

Any police involvement in the past six months? Y/N

_____

At any time? Y/N

Describe:

_____
_____
_____

Any peace bonds/restraining orders? Y/N

Describe:

_____
_____
_____

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Any history of charges being laid, incarceration or probation? Y/N

Describe:

_____
_____
_____

Therapy Oriented Information:

What are your top three worries at this time?

_____
_____
_____

What are your top three goals at this time?

_____
_____
_____

What is your biggest strength?

_____
_____
_____

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What would you like to work on in counselling?

_____
_____
_____

In case of an emergency, whom shall we notify (name and relationship to you):

_____

_____

ADDITIONAL INFORMATION

_____
_____
_____
_____
_____
_____
_____
_____