Purposeful
COUNSELLING
1239 Manahan Ave
Winnipeg, MB, R3T 5S8
purposefulcounselling@gmail.com

Client Intake Questionnaire

Please complete this form as accurately as possible PRIOR to your appointment with your therapist. This will allow for more time to discuss your current concerns.

Name: _____ **Date of Birth:** _____

Address: (street) _____ (city) _____ (postal code) _____

Phone Number(s): _____ **Can we leave a message? Yes No**

Email address: _____

Name and location of Primary Care Provider (e.g., family doctor, nurse practitioner):

_____

_____

Emergency Contact Person: (name and relationship to you) _____

Emergency Contact Phone Number: _____

How did you hear about Purposeful Counselling? (e.g. word of mouth, Psychology Today, website): _____

Current Distressing Symptoms (please include all symptoms being experienced that cause functional impairment such as avoidance, impulsivity, or sleep changes):

Medical History (please include all pre-existing & current medical conditions i.e. asthma, heart conditions etc.):

Surgical History (please include any previous surgeries and month/year):

Psychiatric History (please include any psychiatric or substance use hospitalizations and diagnoses made):

Current Medication List (please include over the counter medications, vitamins, supplements and birth control).

Medication Name	Dose	Frequency	Purpose of Medication

Any previously tried Psychiatric Medications:

Medication Name	Dose	Frequency	Purpose of Medication

Family Psychiatric/Developmental History (please include known psychiatric diagnoses in blood-related family members, e.g. depression, anxiety, OCD, schizophrenia, substance use disorder):

What would you like to accomplish out of your time in therapy? (please include all goals for improvement such as increased confidence, discontinuation of self-harm behaviours, maintenance of employment or school attendance):

What other concerns do you have? (please share information about the status of family relationships, friendships, love interests or other stressors that relate to your functioning):

Cancellation Policy

Clients who cancel with less than 24 hrs before your appointment time or do not show up to their scheduled appointment will be billed for the full cost of their scheduled session.

I, _____, consent to receive therapeutic services from Purposeful
(Client's name)

Counselling therapist and agree to the cancellation policy.

Signed by _____ on this day _____.