Dr. John E. Charlton, DMin | RCC (#9168)
#204 – 3306 32nd Ave., Vernon, BC, V1T-2M6

250 307 0251
john@drjohnecharlton.com
www.drjohnecharlton.com

INTAKE FORM

Name _____ Age _____ Sex _____ Date of Birth _____

Street Address _____ Phone (h) _____

City, Province, Postal _____ Phone (w) _____

Email Address _____ Phone (c) _____

For confidentiality, when and where do you prefer to be reached? _____

Current Marital Status:

☐Single ☐Engaged ☐Married ☐Separated ☐Divorced

When Married/Separated _____ Number of Marriages _____

Spouse's Name: _____ Date of Birth _____

Number of Children & Ages: _____

Presently Living With:

☐Parents ☐Spouse ☐Roommate(s) ☐Alone ☐Other

Emergency Contact:

Name _____

Phone _____

Relationship to you _____

Who referred you or how did you hear about us? _____

Please list specific days/times for your appointment availability:

Monday	□ morning	□ afternoon	□ evening
Tuesday	□ morning	□ afternoon	□ evening
Wednesday	□ morning	□ afternoon	□ evening
Thursday	□ morning	□ afternoon	□ evening
Friday	□ morning	□ afternoon	□ evening
Saturday	□ morning	□ afternoon	□ evening

What type of counselling are you seeking? ***Please select one:***

TYPE	DESCRIPTION	FORMS
☐ Individual	1-on-1 counselling	1 Intake form
☐ Couple	Couples needing guidance	1 Intake form per person over 18 years
☐ Other	Couples needing guidance	1 Intake form per person over 18 years under 18, parent/guardian signs too.

REASONS FOR SEEKING HELP

What concerns have led you to pursue counselling?

What are your concerns causing the most problems for you?

Check all that apply: ☐Home ☐Work ☐Marriage ☐God ☐Other relationships

When did your present concern being to be a problem for you?

Have any concerns about you been identified by others?

Please rate the severity of your present concerns on the following scale. Check one: ☐Mild ☐Moderate ☐Severe ☐Total Incapacitating

Please indicate which of the following areas are currently problems for you. Check all that apply:

□ Abuse of alcohol or non-prescription drugs
□ Anger
□ Blackouts or temporary loss of memory
□ Concerns about finances
□ Concerns about physical health
□ Crying spells
□ Delusions
□ Difficulty making decisions
□ Difficulty making friends
□ Excessive anxiety/worry
□ Excessive fear or specific places/objects
□ Feeling as if you'd be better off dead
□ Feeling distant from God/Higher Power
□ Feeling lonely
□ Feeling manipulated or controlled by others
□ Feeling 'numb' or cut off from emotions
□ Feeling sexually attracted to members of your own sex
□ Feeling that people are 'out to get you'
□ Feeling trapped in rooms/buildings
□ Hallucinations
□ Hearing voices
□ Inability of concentrate
□ Inability to control thoughts
□ Insomnia (no sleep) or Hypersomnia (always sleep)
□ Lack of motivation
□ Lack of self-confidence
□ Loss of appetite/Increased appetite
□ Loss of interest in sexual relationships
□ Loss of interest in usual activities
□ Obsessions or compulsions with specific activities
□ Under too much pressure/stress

MEDICAL/HEALTH INFORMATION

☐ Good ☐ Fair ☐ Poor Date of last physical examination: _____

Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems) ☐ yes ☐ no.

If yes, please explain:

MEDICATION(S) Over-the-counter or prescription DOSAGE

Previous hospitalizations for medical reasons:

Date _____ Reason _____

Date _____ Reason _____

Have you ever been hospitalized for psychiatric purposes? ☐ Yes ☐ No

If yes, please explain including name of hospital, location an dates:

If you have previously had counselling, do you give permission to contact previous counsellor? ☐ Yes ☐ No

Please list names of any previous counsellors or therapists, including dates and contact number:

Name	Date	Contact Number
Name	Date	Contact Number

How do you feel about the results of your previous counselling?

What do you hope to gain from counselling?

OCCUPATIONAL/EDUCATIONAL INFORMATION

Occupation _____ Employer _____

Annual Income: $_____

If currently a student, field of study: _____

College or University: _____

RELIGIOUS/SPIRITUAL BACKGROUND *(optional)*

Do you believe in God/Creator/Higher Power? ☐Yes ☐No.

Religious/Spirituality affiliation: _____

What church do you currently attend? _____

How much influence does your religion have on your day-to-day activity?

CONSENT FOR RELEASE OF INFORMATION

In the event that I am not available to address your needs, due to scheduling or otherwise, I am authorized to release all intake information to a referred counsellor. The consent for release of information avoids any delays in beginning counselling and insures that you receive appropriate care.

Signed _____ Date _____