Think Rational
Feel Positive &
Behave Constructive
DR. GHAZAL DAWOODI

Dr. Ghazal Dawoodi, Ph.D, RCC.
Seawall Medical Centre
#102 - 1590 Bellevue Ave.,
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COUNSELLING INTAKE FORM

Please provide the following information and answer the questions below.
Please note: The information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street Number, Street Name)

_____
(City) (Province/State) (Postal Code/Zip)

Occupation: _____

Home Phone: (_____)_____ May we leave a message? ☐ Yes ☐ No

Cell Phone/Other: (_____)_____ May we leave a message? ☐ Yes ☐ No

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status:
☐ Married ☐ Never Married ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age: _____

Referred by (if any): _____

Health and Personal Information
Have you previously received mental health services? (psychotherapy, psychiatric services etc.)

☐ Yes (date & reason): _____

☐ No

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Have you ever been prescribed psychiatric medication?

☐ Yes (please provide list & dates): _____

_____

☐ No

Is there a history of mental health issues in your family?

Yes, please explain:_____

_____

☐ No

Do you currently have thoughts of suicide?	Yes	No	
Do you have a plan?	Yes	No	
Do you intend to carry out?	Yes	No	
Have you ever attempted suicide?	Yes	No	
Do you take any:			
Prescription medication?	Yes	No	Specify:_____
Tobacco?	Yes	No	# of cigarettes per day____ per week____
Alcohol?	Yes	No	# of drinks per occasion _____
Marijuana?	Yes	No	# of occasions per month_____
Other drugs?	Yes	No	

_____
(cocaine, ecstasy/MDMA, mushrooms, LSD, heroin, other)

Description on Present Problem
Why did you decide to seek counselling?

_____

What do you want to work on while in counselling?

_____

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How long has this been a significant problem for you? Please be specific (i.e., not "all my life")

_____

How would you estimate the severity of the problem at this time?

☐ Mild ☐ Moderate ☐ Serious ☐ Severe

Client Signature: _____ Date: _____

Counsellor signature: _____ Date: _____