EMBODIED HEALING
COUNSELING SERVICES
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Angela Herzog MA, RP, CCC

Client Intake Form

Date:				
Last name:			First name:	
Date of birth:	Month	Day	Year	Age:
Street address:				
Province:			Postal code:	

Home phone: ( )	Call you at home? ☐Yes No☐ Leave a message at home? ☐Yes No☐
Cell phone:	Call you on your cell? ☐Yes No☐ Leave a message on your cell? ☐Yes No☐
Name of person to contact in emergency:	Their relationship to you: Home phone: ( ) Cell phone: ( )

Employment status: ☐ Full time ☐Part time ☐ Unemployed ☐ Disability ☐ Retired

If you are a student ☐ Full time ☐ Part time Name of school:

What is bringing you into counselling:

Have you had previous counselling? ☐ Yes ☐ No
When: Number of sessions:

Have you received a mental health Diagnosis and/or Medication:

Have you been hospitalized for mental illness? ☐ Yes ☐ No
If yes, please list when, for how long, and for what reason?

Have you ever had thoughts of committing suicide? ☐ Yes ☐ No
If so, are you currently experiencing thoughts of committing suicide?
☐ Yes ☐ No

What are your goals for counselling ?

Signature:

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