Dr. Shari Geller
Registered Psychologist
www.sharigeller.ca

200- 250 Eglinton Avenue West,
Toronto ON, M4R 1A7
Tel: 416-855-CMBH (2624)
Fax: 647-729-5551

CLIENT INTAKE FORM

Date: _____

First Name: _____
Last Name: _____

Gender: ☐ Male ☐ Female ☐ Other-Describe: _____

Please describe your main reasons for seeking services at this time? _____

_____

CURRENT RELATIONSHIP STATUS

□ Single □ Common Law □ Separated □ Widowed □ Cohabitating
□ Married □ Divorced □ Polyamory □ Other _____

How is your current relationship (if applicable)? _____

_____

_____

FAMILY INFORMATION (please complete all applicable)

Relationship	Name(s)	M/F	Date of Birth	Living with You?
Mother(s)				
Father (s)				
Partner/Spouse				
Children				

SIGNIFICANT OTHERS (brothers, sisters, grandparents, step-relatives, half-relatives, etc... Please specify relationship)

Relationship	Name	M/F	Date of Birth	Living with You?

OTHER FAMILY INFORMATION (parent's separated, divorced, remarried, family members who are deceased, other special circumstances): _____

_____

_____

_____

Dr. Shari Geller
Registered Psychologist
www.sharigeller.ca

EDUCATION

	Completed	Partial	
Elementary	□	Grade ____	
High School/GED	□	Grade ____	
College/University	□	□	Program/Degree _____ / _____
Graduate School	□	□	Program/Degree _____ / _____

Other Training_____

Special Circumstances (learning disabilities, gifted, etc.)_____

EMPLOYMENT

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position?_____

If yes, are you happy at your current position?_____

PHYSICAL HEALTH

How is your overall physical health at present? (please check one)

□ Very good □ Good □ Okay □ Poor □ Bad

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid issues, etc.):

_____

_____

_____

_____

EXERCISE

What do you engage in for exercise?_____

How often do you exercise?_____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters?

□ Not at all □ Little □ Moderate □ Very much

How important to you are religious matters?

□ Not at all □ Little □ Moderate □ Very much

Dr. Shari Geller
Registered Psychologist
www.sharigeller.ca

CURRENT ISSUES

Have you struggled with the any of the following issues? Check all that apply.

Issue	Current	Past	Issue	Current	Past
Stress/Trouble coping			Suicidal Thoughts		
Sleep problems			Trauma symptoms		
Grief			Dissociation		
Depression			Mental confusion		
Anxiety			Eating disorder		
Panic Attacks			Addictive behaviors		
Fear/phobias			Alcohol concerns		
Interpersonal problems			Drug use		
Sexual issues			Self-harm		
Sexuality or Gender			Other : (specify)		

Have you ever received a diagnosis from a doctor for any of the above or for any other relevant issue? _____

_____

If so, who made the diagnosis? _____

Have you ever attempted suicide? □ Yes □ No
If yes, when: _____
Has a family member ever attempted/committed suicide? □ Yes □ No
If yes, who: _____

Have you ever engaged deliberately in self-harm behavior(s)? □ Yes □ No

MEDICATIONS

Are you currently prescribed any medications? □ Yes □ No
If yes, please list all of your currently prescribed medications below.

Name of Medication	Date prescribed	Dose (mg)	Purpose	Name of Prescriber

VITAMINS/NATUROPATHIC REMEDIES

Are you currently taking any natural remedies or vitamins? □ Yes □ No
If yes, please list all of the vitamins/remedies you are currently taking below.

Name of Vitamin /Remedy	Date Started	Dose (mg)	Purpose

Dr. Shari Geller
Registered Psychologist
www.sharigeller.ca

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family experienced difficulties with the following? (Check any that apply and list family member, e.g., sibling, parent, uncle, grandparent, etc.):

Difficulty	Experienced	Relationship to You
Depression	□ Yes □ No	
Bipolar Disorder	□ Yes □ No	
Anxiety Disorders	□ Yes □ No	
Panic Attacks	□ Yes □ No	
Schizophrenia	□ Yes □ No	
Alcohol/Substance Abuse	□ Yes □ No	
Eating Disorders	□ Yes □ No	
Learning Disabilities	□ Yes □ No	
Trauma History	□ Yes □ No	
Suicide Attempts	□ Yes □ No	

ALCOHOL/SUBSTANCE USE

What is your average number of alcoholic drinks you have in a week? _____

Do you use any substances/drugs recreationally? _____
If so, please name which substances: _____

Does/has someone in your family have/had a problem with alcohol or substance use?
□ Yes □ No
If yes, describe: _____

SLEEP HABITS

Are you having any problems with your sleep? □ Yes □ No
If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams
□ Other _____

PSYCHOTHERAPY/TREATMENT HISTORY

Do you currently have an individual therapist, psychiatrist, or any other person helping you with mental or emotional health concerns? □ Yes □ No

Have you ever received psychotherapy/psychiatric treatment? □ Yes □ No
Have you ever received alcohol or drug use treatment? □ Yes □ No
Have you ever been hospitalized for mental health issues? □ Yes □ No

If yes to receiving any of the above services, as best as you can, please list current and past providers in the table below.

PSYCHOTHERAPY/PSYCHIATRIC TREATMENT			
Name of Provider/Treatment Program	Current Primary Provider?	Date Started/Ended Treatment	Response to Overall Experience
	☐Yes ☐No		☐Good ☐Fair ☐Poor
	☐Yes ☐No		☐Good ☐Fair ☐Poor
	☐Yes ☐No		☐Good ☐Fair ☐Poor
ALCOHOL OR DRUG USE TREATMENT			
	☐Yes ☐No		☐Good ☐Fair ☐Poor
	☐Yes ☐No		☐Good ☐Fair ☐Poor
	☐Yes ☐No		☐Good ☐Fair ☐Poor
PSYCHIATRIC HOSPITALIZATION			
	☐Yes ☐No		☐Good ☐Fair ☐Poor
	☐Yes ☐No		☐Good ☐Fair ☐Poor
	☐Yes ☐No		☐Good ☐Fair ☐Poor

LEISURE/RECREATIONAL ACTIVITIES

Describe special areas of interest or hobbies (e.g., art, books, writing, crafts, physical fitness, sports, outdoor activities, spiritual activities, walking, exercising, diet/health, meditation, yoga, traveling, etc.)

Activity	**How Often Now?**	**How Often in the Past?**

What do you consider to be your strengths? _____

_____

_____

_____

What are effective coping strategies that you currently use? _____

_____

_____

_____

Dr. Shari Geller
Registered Psychologist
www.sharigeller.ca

Describe your support network (friends, family, community supports)?_____

_____

_____

_____

What are your goals for treatment? _____

_____

_____

_____

_____

_____

_____

Any additional information that would assist us in understanding your concerns or problems:

_____

_____

_____

_____

FOR STAFF USE ONLY

Date:_____

Therapist Name:_____ Therapist Signature:_____