Cascadia

COUNSELLING CLINIC LTD.

INTAKE FORM

Intake Date: _____

Name(s): _____ Date(s) of Birth _____

_____ _____

_____ _____

Home Address: _____ Ph-HM _____

Postal Code: _____ Ph-WK _____

E-mail Address: _____

☐ Please email me receipts. ☐ Please do not send me any promotional email.

Employer: _____ School _____

Call in case of an emergency: _____

Closest ER to your home (for virtual sessions): _____

Referred to Cascadia by: _____

Family Doctor: _____ Recent Treatment: _____

Current Medications: _____ Illness: _____

Alcohol/day: _____ Drugs/Nicotine/Caffeine _____

Members of household:

Name	Date of Birth	Relationship to Client

Presenting Issue: (client's perspective)

_____

_____

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