Evolving Story Counselling and Consulting
Maedean Yvonne Myers, RCC, CCC, RYT
compassionate counselling for healing hearts

Counselling Intake Form

(*Please fill out any information you are willing to share at this point that you believe to be relevant to our work together)*

Legal Name:_____ **Date:**_____
Preferred Name: _____ **Preferred Pronouns:**_____
Date of Birth:_____
Email:_____
Phone:_____

Any allergies or health conditions that you think I should know about?

_____

Any medications that you think I should know about?_____

In your own words state the nature of your main problems:

_____
_____
_____
_____
_____
_____

Are you struggling with any of the below?

☐ Alcohol ☐ Drugs other than Marijuana ☐ Gambling ☐ Marijuana ☐ Internet Use ☐ Tobacco Smoking ☐ I'm not sure if I'm struggling ☐ Other:_____

What symptoms are you currently experiencing?

☐ Anxiousness, Nervousness ☐ Chronic Sadness ☐ Issues with sleep ☐Fearfulness ☐ Crying, feeling emotional ☐ Conflict with others ☐ Feeling ashamed, guilty ☐ Taking on too many tasks

☐ Procrastinating, avoiding certain tasks ☐ Numbing out with food, tv or other distractions ☐ Chronic Sadness ☐ Body image issues ☐ Loss of appetite ☐ Thinking too much, ruminating, worrying ☐ Conflict with others ☐ Relationship issues ☐ Intrusive thoughts about past difficult experiences ☐ Other:_____

What solutions to your problems have been the most helpful to date *(attitudes, faith practices, hobbies, activities, supportive people)*

_____
_____
_____

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Trauma and/ or Significant Losses

Have you had previous trauma related to any of the following:

☐ Physical ☐ Emotional ☐ Sexual ☐ Abortion ☐ Witness to crime ☐ Victim of crime

☐ Corporal Punishment ☐ Discrimination ☐ Historical Trauma ☐ Internet Coercion

☐ Trauma as a Result of a Cultural or Religious Practice ☐ Witness to Domestic Violence

☐ Significant Loss through divorce, separation, death of a loved one ☐ Job Loss
☐ Other:_____

Family History

Did your immediate family members, chosen or birth cope with any of the following:

☐ alcoholism ☐ allergies ☐ anxiety ☐ depression ☐ disordered eating

☐ domestic violence ☐ drug use ☐ financial stress ☐ health issues

☐ high blood pressure ☐ learning disability ☐legal problems ☐ medical problems

☐strong religious beliefs ☐ other mental/emotional health concerns_____

Suicide Risk Assessment

Please check your level of risk.

Harm to Self: None_____ Low_____Medium _____ High _____

Harm to Others: None_____ Low_____Medium _____ High _____

Treatment Goals

What would you like to achieve in our work together:

1.

2.

3.

Please provide an emergency contact number:

NAME _____
NUMBER_____