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**Client Intake Form (Pre-Consultation)**

| **Section** | **Details/Instructions** |
| --- | --- |
| **Client Information** |  |
| Full Name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Birth (DD/MM/YYYY) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Gender | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone Number | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email Address | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Preferred Contact Method | [ ] Phone [ ] Email [ ] Text |
| Occupation | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Relationship Status | [ ] Single [ ] Married [ ] In a Relationship [ ] Divorced [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Emergency Contact Name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Emergency Contact Phone Number | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Referral Information** |  |
| How did you hear about my services? | [ ] Referral [ ] Website [ ] Google [ ] Social Media [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you previously attended therapy or counselling? | [ ] Yes [ ] No |
| If yes, describe your past therapy experience. What did you find useful or not useful: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Presenting Concerns** |  |
| What brings you to therapy? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How long have you been experiencing these concerns? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How do you feel these issues are impacting your life and relationships? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What are the most pressing issues you would like to address in therapy? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Self-Esteem and Relationship Dynamics** |  |
| How would you describe your self-esteem at this point in your life? | [ ] High [ ] Moderate [ ] Low [ ] Fluctuating |
| Are you currently experiencing any of the following in your relationships? | [ ] Difficulty communicating [ ] Fear of rejection [ ] Repeating unhealthy patterns [ ] Feeling unheard/invisible [ ] Struggling with balancing life [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_ |
| How would you describe your relationships with family, friends, or romantic partners? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Goals for Therapy** |  |
| What would you like to achieve through therapy? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What specific changes would you like to see in your life after therapy? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Background and Support System** |  |
| Do you have a support system (family, friends, colleagues)? | [ ] Yes [ ] No |
| If yes, please describe the nature of your support system: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are there any life events or past experiences that may have shaped your current struggles? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Therapy Preferences** |  |
| Are you open to discussing and exploring the deeper reasons behind your emotions and behaviours? | [ ] Yes [ ] No |
| Do you prefer a more solution-focused or introspective approach in therapy? | [ ] Solution-Focused [ ] Introspective [ ] Both |
| What would make you feel safe and supported during therapy sessions? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Consent and Agreement** |  |
| I understand that therapy is a collaborative process and may involve exploring personal and sensitive topics. | [ ] Yes [ ] No |

**Date:**

**Signature:**