Some verbal and written communication from me to you is necessary from time to time so that I can provide services to you and operate the business side of my practice. Examples include: scheduling appointments, collecting payments, reminders about upcoming appointments, and follow-up to services being provided. Every effort is made, however, to be discrete in contacting you.

Please provide us with as much information as possible so as to make sure our communications with you are as easy, comfortable and efficient as possible.

Contact Information

If each individual has a separate legal surname, please provide the information in the space provided:

Name: _____

Name: _____

Mailing Address: _____
Street Address City Province Postal Code

Phone: Home: _____
(All reminder messages about upcoming appointments will to this number unless otherwise noted)

Cell (His) _____ (Hers) _____

Work (His) _____ (Hers) _____

Special Instructions: _____

Email Address: _____

Email Address: _____

SIGNATURE

I/we give our authorization to be contacted by Sig Taylor, MSW, RSW, RMFT & the Calgary Couples Clinic as outlined above.

_____	_____	_____
Name	Signature	Date
_____	_____	_____
Name	Signature	Date

Intake Questionnaire

Today's Date:

Your Name:

Your Birth Date: Age:

Marital Status: (check all that apply) □ Single □ Never married □ Exclusive dating □ Cohabiting □ Married □ Remarried □ Separated □ Divorced □ Widowed

(If applicable): For how long have you currently been married, cohabiting, separated, divorced, or widowed? _____

How many children do you have? _____

How many of your children live with you? _____

Education: (highest level) □ Some high school □ High school □ Technical / Trades □ 2-year associate degree □ Some undergraduate college or university □ Undergraduate degree □ Some graduate level □ Graduate degree: _____

Income: (household annual) □ $0-30,000 □ $31-60K □ $61-90K □ $91-120K □$120-150K □ $150K +

Current Occupation: _____

Years at Current Job: _____ Hrs per week: _____

Do you enjoy your work? □ A lot □ Moderately □ Very little

Career Goals: _____

SYMPTOM CHECKLIST

On a scale of 0-4 (0=none or not applicable, 1=a little, 2=moderate, 3=a lot, 4=extreme) rate how much you have experienced each symptom over the past two weeks. The first six symptoms (a-f) relate to your relationship with your spouse or partner. (If you are single, circle "0").

	(Circle a number)
a. Not talking to each other	0 1 2 3 4
b. Having bad arguments	0 1 2 3 4
c. Lack of trust between us	0 1 2 3 4
d. Feeling lonely in the relationship	0 1 2 3 4
e. Lack of affection and caring between us	0 1 2 3 4
f. Feeling unhappy about our relationship	0 1 2 3 4
g. Feeling sad, down or depressed	0 1 2 3 4
h. Avoiding certain people or places	0 1 2 3 4
i. Loss of interest in activities I normally enjoy	0 1 2 3 4
j. Low energy/feeling tired	0 1 2 3 4
k. Sleep problems (insomnia, not staying asleep, or early waking)	0 1 2 3 4
l. Eating too much or too little	0 1 2 3 4
m. Not able to think clearly	0 1 2 3 4
n. Feeling no pleasure or joy in life	0 1 2 3 4
o. Anxiety attacks	0 1 2 3 4
p. Worrying about things	0 1 2 3 4
q. Angry outbursts	0 1 2 3 4
r. Low self-esteem or low self-confidence	0 1 2 3 4
s. Feeling guilty	0 1 2 3 4
t. Feeling too stressed	0 1 2 3 4
u. Thoughts of suicide	0 1 2 3 4
v. Drinking too much or abusing drugs (i.e. street drugs or prescribed medications)	0 1 2 3 4
w Acting out other compulsive behaviors (i.e. gambling, sex, porn, shopping, etc.)	0 1 2 3 4
x. Not getting my work done	0 1 2 3 4
y. Feeling unhappy with my workplace	0 1 2 3 4

Symptoms Total: / 100

Medical: Do you have any medical problems? □ Yes □ No

If yes, please list them: _____

_____

Do you take any prescription Medications? □ Yes □ No

If yes, please list them:

Medication Dose Purpose Since

Do you Exercise? □ Yes □ No If yes, what do you do?

_____

Do you drink alcohol? □ Yes □ No

If yes, estimate how many times you typically drink in a month (i.e. how many drinking occasions): _____

Estimate how many standard drinks you typically drink per occasion (estimate your range if it varies): _____

Do you smoke tobacco? □ Yes □ No

If yes, please estimate quantity per day: _____

Do you drink coffee/ tea? □ Yes □ No

If yes, please estimate quantity per day: _____

Do you use any illicit drugs? □ Yes □ No

If yes, please specify: _____

If you drink alcohol or use illicit drugs, please answer the following questions:

C. Have you ever thought you should Cut down on your drinking/ drug use? □ Yes □ No

A. Have people Annoyed you by criticizing your drinking/ drug use? □ Yes □ No

G. Have you ever felt bad or Guilty about your drinking/ drug use? □ Yes □ No

E Have you ever had a drink / used drugs in the morning (Eye opener) to steady your nerves or to get rid of a hangover? □ Yes □ No

Are you concerned about the alcohol and/or drug use of anyone close to you? □ Yes □ No If yes, who?

_____

Are you experiencing abuse in any of your current relationships?

□ Yes □ No If yes: □ Physical □ Emotional □ Sexual

By whom? _____

Have you ever experienced abuse in your past relationships?

□ Yes □ No If yes: □ Physical □ Emotional □ Sexual

By whom? _____

REASONS FOR SEEKING FOR COUNSELING

Check only those that apply. If you check more than one, please select your top three and rank them from highest to lowest in terms of the priority you place on resolving them (1=highest priority, 2=second highest, 3=third highest).

(√) (Check all that apply)	Rank
___ Depressed Mood	_____
___ Anxiety	_____
___ Anger Management	_____
___ Self-Esteem or Confidence	_____
___ Social Difficulties	_____
___ Stress Management	_____
___ Bereavement/ Loss	_____
___ Domestic Violence or Abuse (Current)	_____
___ Premarital Counselling	_____
___ Communication Problems/Relationship Conflict	_____
___ Sexual Intimacy Concerns	_____
___ Emotional or Sexual Infidelity/affairs	_____
___ Other Marital/Relationship Concerns	_____
___ Separation / Divorce / Relationship Break-Up	_____
___ Custody Concerns	_____
___ Parenting	_____
___ Parent-Adult Child Relations	_____
___ Blended Family Issues	_____
___ Family Conflict	_____
___ Work problems	_____
___ Education/ Career Concerns	_____
___ Financial Concerns	_____
___ Legal Concerns	_____
___ Medical Issues	_____
___ Substance Abuse (Alcohol/Drugs)	_____
___ Gambling Difficulties	_____
___ Other Addictions (i.e. Sex, Shopping)	_____
___ Eating Disorder	_____
___ Weight Management / Body Image	_____
___ Spiritual Problems	_____
___ Child - Behavioral Problems	_____
___ Child - Mood / Anxiety Problems	_____
___ Child - Academic Problems	_____
___ Child - Social/ Relational Problems	_____
___ Other _____	_____

PREVIOUS TREATMENT

Have you participated in therapy or counseling in the past?
□ Yes □ No If yes, please specify:

Date	Duration	Therapist / Location	Was it Helpful?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who do you turn to for social support (e.g. for encouragement, advice, friendship, etc.)?

_____
_____
_____

Are there any organizations or agencies that you are currently receiving assistance or support from? □ Yes □ No If yes, please specify: _____
_____
_____

EXTENDED FAMILY HISTORY OF PSYCHOSOCIAL / HEALTH DIFFICULTIES

Please check any of the conditions below that are or have been present in your extended family. Please write any additional explanatory comments that may be helpful for your therapist to understand.

	Who?	When?
□ Depression		
□ Bipolar Disorder		
□ Schizophrenia		
□ Other psychiatric disorders (i.e. psychosis, hallucinations)		
□ Suicide		
□ Physical / Sexual Abuse		
□ Substance Abuse (Alcohol/Drugs)		
□ Autism/Asperger's Syndrome		
□ Eating Disorder		
□ Chronic Illness (please specify illness)		
□ Accidental or Untimely Death		
□ ADHD or Learning Disorders		
□ Other		

OTHER INFORMATION

Please include here any additional background information you feel would be helpful for your therapist to know:

_____
_____
_____
_____
_____
_____
_____
_____

REFERRAL SOURCE

Please let us know how you learned about Sig Taylor, MSW, RSW. (Check all that apply):

□ Internet search / website
□ Word of mouth (family/friend)
□ Another professional (physician, lawyer, etc.)
□ Workshop or seminar
□ I am a returning client
□ My employer or health insurance provider
□ Other _____

Thank you very much for taking the time to fill out this questionnaire.