Ashley MacLellan M.Ed., R.P., C.C.C.

Counselling & Psychotherapy Services

Intake/Client Information Form

Client Name: ______________________________ Date of Birth: _________________

Preferred Language: ________________________ Pronoun(s): ___________________

Referral Source: ______________________________ Date of Referral:__________________

Contact Information

Address: ____

____

Phone No. (C): _____________________________ Phone No. (H): _________________________

Email: ___________________________________ Phone No. (W): _________________________

Preferred methods of contact (Phone, Email, Text): ____

Emergency Contact: ___________________________ Phone No. ______________________________

Current Living Situation

Housing (please include family members/roommates/pets, housing stability)

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- Employment (Full Time / Part Time / Unemployed):
  ____
- Student (Full Time / Part Time / Distance Learning):
  ____
- Home worker: ____
- Retired
- Disabled

Presenting challenges/goals for which therapeutic support is sought: _____________________________

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