**Bridges Intervention Intake Form**

Bridgesintervention.inc@gmail.com
Telephone: 647-668-8755

Full Name ______________________________ Today's Date ______________

Male_____ Female_____ Date of Birth__________ Age__________

Home Address ______________________________________________

City ______________________ Province _______ Postal Code __________

Home Telephone _______________ Is it OK to contact you at home? _________ OK to leave a message? __________

Mobile Telephone _______________ Is it OK to contact this number? _________ OK to leave a message? __________

How did you learn about the psychotherapy services provided at this office: ______________________________
______________________________________________

**REASON FOR SEEKING TREATMENT:**
Please briefly describe the problems you are experiencing.

______________________________________________
______________________________________________
______________________________________________
______________________________________________

What has happened to cause you to seek help now?

______________________________________________
______________________________________________

What do you hope to be able to do or achieve as a result of treatment?

______________________________________________
______________________________________________

Do you currently have thoughts of harming yourself? ☐ yes ☐ no
Have you in the past? ☐ yes ☐ no If Yes, how long ago? ______________________

Have you **ever** seriously considered suicide or felt like harming someone else? ☐ yes ☐ no
If yes, please explain: ______________________________________

Name of Current Medical doctor (and phone #):
______________________________________

Have you ever had previous therapy/counseling of any kind? ☐ yes ☐ no If yes, when, and for how long?

______________________________________________
______________________________________________

Have you ever been hospitalized for emotional problems? ☐ yes ☐ no or for substance abuse problems? ☐ yes ☐ no
If yes to either of the above, please note when, where, and for how long were you hospitalized? ______________
______________________________________________

Have you ever experienced a problem with alcohol, drugs, or prescription medications? ☐ yes ☐ no
If yes, please explain: ______________________________________

______________________________________________________________________________

______________________________________________________________________________

Have you ever been treated for problems with alcohol, drugs, or abuse or prescription medications? ☐ yes ☐ no

If yes, please explain: ____________________________________________________________

______________________________________________________________________________

Has drinking or drug use ever caused you problems in the following areas (check if yes): ☐ family ☐ school ☐ employment ☐ legal ☐ emotional ☐ social ☐ financial ☐ behavior ☐ physical health

Please describe your relationships with other family members:

| Relationship | Living? | Describe quality of relationship |
|---|---|---|
| Father | ☐ yes ☐ no ☐ n/a | ______________________________ |
| Mother | ☐ yes ☐ no ☐ n/a | ______________________________ |
| Step-father | ☐ yes ☐ no ☐ n/a | ______________________________ |
| Step-mother | ☐ yes ☐ no ☐ n/a | ______________________________ |
| Spouse/partner | ☐ yes ☐ no ☐ n/a | ______________________________ |
| Sister(s) | ☐ yes ☐ no ☐ n/a | ______________________________ |
| Brother(s) | ☐ yes ☐ no ☐ n/a | ______________________________ |
| In-Laws | ☐ yes ☐ no ☐ n/a | ______________________________ |

Whom were you raised by? ____________________________________________

What family member(s) were you closest to as a child?

______________________________________________________________________________

______________________________________________________________________________

What family members(s) are you closest to now? _____________________________________________

______________________________________________________________________________

**MARITAL STATUS:**

Marital/relationship status (Check one) Married; Live with partner (check if same ___ or opposite___ sex); Single; Separated/Divorced; Widowed; or Other: _______________

Comments regarding stresses in current or previous marriage(s)/relationship(s): _______________________

______________________________________________________________________________

______________________________________________________________________________

If you have had problems in the past, what do you think caused those relationships to end? ______________

______________________________________________________________________________

______________________________________________________________________________

Have you ever been abused mentally or physically by a romantic partner? ☐ yes ☐ no

Does this apply to your current relationship? ☐ yes ☐ no

Do you feel safe? ☐ yes ☐ no

**EMPLOYMENT/EDUCATION INFORMATION:**

Check all that apply: employed retired disabled student homemaker unemployed

If/When employed, what type of work do you do? ________________________________________________
________________________________________________________________________________

**HEALTH/MEDICAL INFORMATION:**

Please list significant medical problems/conditions, and indicate if you are receiving treatment for them: _____________
________________________________________________________________________________
________________________________________________________________________________

Do any of these problems affect your everyday life? □ yes □ no If yes, how so? ________________________
________________________________________________________________________________

________________________________________________________________________________

List all medications that you currently use:

Medication(s) ______________________________________________________________________
________________________________________________________________________________

Dosage (amount and times per day) ___________________________________________________

Reason(s)__________________________________________________________________________

**IN CASE OF EMERGENCY, PLEASE NOTIFY:**

Name: ____________________________________ Relationship ___________________________

Address ________________________________________________________________________
(Street, Apt #) (City) (Province ) (Postal Code)

Telephone # Daytime ________________________ Evening __________________________

Cell Phone________________________

**Fees and payment:** Sessions are approximately 50-60 minutes in length. Every attempt is made to see clients on time. To work towards this goal, payment is due at the ***start*** of each session. Payments can be made by email to: bridgesintervention.inc@gmail.com

**TWENTY-FOUR (24) hours' notice *is required to* CANCEL OR RESECHEDULE *an appointment to avoid being billed for the full fee of the missed session*. EXCEPTIONS ARE UNEXPECTED ILLNESS OR EMERGENCIES.**

**Mutual rights and responsibilities:** The relationship must remain limited to a respectful therapeutic framework. You may refuse any therapeutic suggestions offered to you, or to suspend or cease treatment at any time without penalty. *If you decide to stop treatment for any reason, please notify your therapist so that your file can be closed and/or you can be referred to another resource. If you stop treatment without an explanation, your file will automatically be closed after 30 days.*

*Signature:* ___________________________ Date: ________________