Session with Véronique Roux

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NEW CLIENT INTAKE FORM

CLIENT	Gender / preferred pronoun:	DOB (mm/dd/yy):	Age:
First Name:	Surname:		
Address:	City:	Postal Code:	
Phone(s): (private/okay to leave messages?) mobile: (☐ Yes ☐ No) home: (☐ Yes ☐ No) other: (☐ Yes ☐ No)	Preferences: ☐ evening ☐ day ☐ evening ☐ day ☐ evening ☐ day		
Email: private? ☐ Yes ☐ No			
Status: ☐ Single ☐ Married ☐ Common-Law ☐ Separated ☐ Blended *Other:* Length of time in present relationship:			
Date of initial session, if known:			
Local emergency contact:	Relationship:		
Emergency contact phone:	Mobile:	☐ Home: / ☐ Work:	

Have you ever:

- ☐ Struggled with any kind of addiction? If yes, please detail:
- ☐ Considered suicide? If yes, when? Currently?
- ☐ Had / thought you had an eating disorder? If yes, when? Currently?
- ☐ Been diagnosed by a medical professional with a mental illness or DSM disorder (such as panic/anxiety disorder, major depression, borderline personality disorder, etc. More details here). If so, please list:

Approximate date of diagnosis:

Medical Conditions:

Family doctor:

Phone:

Are you currently taking medication? ☐ Yes ☐ No (if yes, please list):

Medication	Reason

Do you have a family history of:

- ☐ Mental health issues or DSM disorder, as above
- ☐ Eating disorders
- ☐ Serious illness
- ☐ Any kind of addiction

If you checked any of the above, please provide details: