TALK THERAPY
INDIVIDUAL, COUPLE & FAMILY THERAPY

Lori Dennis, B.A., M.A., R.P., Member - CRPO, OAMHP, OSRP, CAPT
Registered Psychotherapist

416.709.8117 | loridennis@talktherapy.ca | talktherapy.ca

INTAKE FORM

Name:

Address:

Email:

Telephone Number(s):

Age: Date of Birth:

EMERGENCY CONTACT PERSON

Name:

Email:

Telephone Number(s):

1ST APPOINTMENT

Date and Time:

Referred By:

CONSENT FORM & POLICY STATEMENT

(Feel Free To Include as Much or as Little as You Are Comfortable Disclosing Here)

Read, Understood And Signed By Client ■ Yes ☐ No

Description of Presenting Problem:

What Prompted You To Reach Out?

When/how Did The Problem Begin? (Dates/Symptoms)

What Else Was Going On At The Time?

What Solutions To Your Problems Have Been Most Helpful?

CONT'D ON NEXT PAGE

TREATMENT & MEDICAL HISTORY

Family PhysicianName

Name:

Telephone Number(s):

Have you ever received professional counseling for your current problems, or any other problems? ☐ Yes ☐ No

If so, list name (s), professional title(s), and dates of treatments and results.

Do you have any current health or medical conditions requiring medication? ☐ Yes ☐ No

If so, please list all prescription medications you are currently taking. (Dosage/Reasons/Past Medications)

Suicidal Ideation or Past Attempts?

Goals of Therapy

1.
2.
3.