new leaf
psychological services

Intake Screening

Name:_____
Last First MI

Date of Birth_____ Gender: ❒male ❒female

Are you under 18 years of age? Yes_____ No _____ Age_____

Address:_____

City/Province/Postal Code:_____

Home Phone: (_____)_____ Work Phone:(_____)_____

Cell Phone: (_____)_____ E-mail:_____

Do you have any objections to being contacted by telephone, mail, e-mail, etc…❒ yes ❒ no

Do you have any objections to messages being left for you…❒ yes ❒ no

How would you like to be contacted? _____

Emergency Contact Name:_____ Relationship:_____
Address:_____
City/Province/Postal Code:_____
Home Phone:_____
E-mail:_____

Nature of Concern:
_____
_____
_____

Are you having suicidal thoughts? Yes_____ No_____

Are you planning to hurt someone? Yes_____ No_____

Is sexual assault/abuse an issue? Yes_____ No_____

Are you concerned that you might be anorexic or bulimic? Yes_____ No _____

Does this concern a problem with either alcohol or drugs? Yes_____ No_____

Who is your family physician: _____

Referred by: _____