Dr Christine Slonetsky, ND 1045, RSW, MSW 803663
www.christineslonetsky.com

Counselling Intake Form

Date: _________________________

Treating Practitioner: Christine Slonetsky, ND, RSW, MSW

Counselling: EAP Provider YES / NO

Provider: ____________________________ Certificate # ____________________________

Extended Health Benefits YES / NO Name of Provider: ________________________

First Name _____________________________________

Middle Initial ________

Last Name ______________________________________

Address ____

City _____________________________ **Prov.** _______ **Postal Code** ___________________

Date of Birth (D/M/YY) ________________________ **Age**:______ **Gender:** F / M

Phone Number: Preferred contact no. ____________________________ ( ) cell ( ) home

Can we leave a message? Y / N

Secondary Contact no. __________________________ ( ) cell ( ) home ( ) work

Can we leave a message? Y / N

Email: ____

(We send email reminders for appointments)

Referral Source: ( ) EAP Provider ( ) Internet/Website ( ) Family/Friend ( ) Medical Provider ( ) Brochure ( ) Other: _________________________

Are you seeing another practitioner in our office? Y / N Chiropractor/Massage therapist/Naturopath

If Yes who? _______________________________________

Type of Counselling Requesting ( ) Individual ( ) Couples Counselling

Previous Counselling: Y / N If yes, where/when: __________________________

Marital Status ( ) Single ( ) Married ( ) Separated ( ) Divorce ( ) Common-Law

Presenting Problem ( )Abuse ( ) Addictions ( ) Anger ( ) Anxiety ( ) Depression
( ) Domestic Violence ( ) Emotional ( ) Family ( ) Relationship
( ) Stress ( ) Trauma ( ) Work ( ) Other

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