CATHOLIC FAMILY SERVICES of Prince Albert

#300 - 1008 1st Avenue West
Prince Albert, Sk., S6V 4Y4
ETransfer:cfspamobile1@gmail.com
Phone: (306) 922-3202
Fax: (306) 922-7977
Toll Free: 1-877-922-3202
E-mail: cfspa@sasktel.net
Website: www.cfspa.ca

Counselling Intake Form

Date:_____

Primary Client:

Name:_____Gender:_____

Birthdate:_____
(Month/Day/Year)

Telephone:_____ *Can we leave a message at this number?*_____
(include area code)

Alternate Telephone:_____ *Can we leave a message at this number?*_____
(include area code)

Email:_____

Mailing address:_____

Town/City _____Postal Code:_____

Family Members
If additional family member will be joining counselling, please list below and include their **Name, Birthdate, gender, contact information and relationship to Primary Client.** *If Primary Client is under 18, please list details for* ***Custodial Parent(s) and /or Legal Guardian(s).***

Emergency Contact Name:_____Telephone:_____
(include area code)

Reason for seeking counselling at CFS:

Do you have a Mental Health Diagnosis? _____If *Yes,* please identify:_____
Are you currently prescribed medication related to the Diagnosis? _____ If *Yes,* please prepare a list of any/all medications to inform your counsellor during your first counselling session.

Please sign or type your full (legal) name below. By providing your typed name, you are agreeing that your electronic signature is the legal equivalent of your manual signature on this form.

Signature:_____ **Date**_____