

Office Use Only

Scheduled Intake:	Intake Counsellor:
Urgent Appointment: (Date seen/provider)	Wellness Card Provided? Yes No

Student Information

To assist in finding the right support for you, please fill in the information below to help us understand who you are and what services you may need.

Date Submitted (dd/mm/yyyy)	Name	Preferred Name		
Student Number 	NSID	Date of birth (dd/mm/yyyy)	Age	Gender Female Male Other
Health Number	Province of Health Insurance		Health Number Expiry Date (mm/yyyy)	
<input type="checkbox"/> I live in Usask residences (Ask to see the Residence Intake Counsellor) <input type="checkbox"/> I do not live in USask residences		Current Street Address		
City/Town	Province	Postal/Zip Code	Telephone Number	Can we leave a message? Yes No
Email Address	Were you referred to our service? Yes No		If yes, by whom?	

If you need assistance for an urgent situation outside of our regular operating hours, contact:

- Saskatoon Police Service **911**
- University Protective Services **306-966-5555**
- Royal University Hospital Emergency **103 Hospital Dr.**
- Saskatoon Mobile Crisis **306-933-6200**
- Crisis Services Canada **1-833-456-4566**
- Sexual Assault Crisis line **306-244-2224**
- Crisis text line **Text HOME to 686868**

Legal Next of Kin/Emergency Contact

Name		Relationship to you	
Street Address		City/Town	Phone Number

Academic Information

Are you currently registered in classes? Yes No		If no, when are you returning to classes:		Full time student		Domestic student	
				Part time student		International student	
College			Department			Year in Program	
How would you describe your academic health? (i.e. change in grades, stress, procrastination, perfectionism etc.)							

Mental and Physical Health

Are you currently receiving counselling elsewhere? Yes No		If yes, where and by whom?	
Have you ever seen a counsellor at the University of Saskatchewan? Yes No		If yes, who did you see and when?	
Primary physician		Psychiatrist	
Any past or present mental health concerns or diagnosis (i.e. ADHD, Depression, anxiety, OCD)			
Any past or present significant health issues or concerns			
Current medications			
Present general emotional state: (i.e: anxious, content, frustrated, confused, excited, overwhelmed, sad, lonely etc.)			
Do you have a history of depression? If yes, please explain:		Yes No	
Does anyone in your family have a history of depression? If yes, please explain		Yes No Not Sure	

Current symptom checklist

Rate intensity of symptoms presently experiencing: **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning; **Moderate** = Significant impact on quality of life and/or day-to-day functioning; **Severe** = Profound impact on quality of life and/or day-to-day functioning.

	N/A	Mild	Mod	Severe	How long?		N/A	Mild	Mod	Severe	How long?
Depressed mood						Binging / purging					
Sadness						Anorexia					
Hopelessness						Laxative / diuretic misuse					
Frequent tearfulness						Hyperactivity					
Appetite disturbance						Elevated mood					
Sleep disturbance						Hallucinations					
Fatigue / low energy						Paranoid ideation					
Poor concentration						Delusions					
Poor memory						Panic attacks					
Mood swings						Generalized anxiety					
Agitation						Avoidance behaviours					
Irritability						Self-harm					
Conduct problems						Grief / loss					
Aggressive behaviours						Loneliness					
Sexual dysfunction						Isolation / withdrawal					
Phobias						Obsessions / compulsions					

Substance Use/Problem Habits

Substance	Type of Substance	Frequency of Use (daily, weekly, monthly, etc.)	Amount of Use (ie. # of drinks consumed per day/week etc.)
Alcohol			
Cannabis			
Other:			
Other:			
Have you ever tried to cut down on any of your alcohol/drug use?		Yes	No
Has anyone ever expressed concern about your alcohol/drug use?		Yes	No
Have you ever felt bad/guilty about your alcohol/drug use?		Yes	No
Any problem habits or addictions present in your life? (i.e. over/under sleeping, over/under eating, internet, pornography, smoking, vaping, shopping, sex, gambling etc.)			
Yes No If yes, please explain:			

Trauma History

Incidence of trauma in your life (sexual abuse, sexual assault, accident or witnessed accident, traumatic medical procedure, abuse or witnessed abuse, etc.)	
Yes No If yes, please explain:	

Presenting Issue

What is the presenting issue or main concern for seeking services today?

How troubling are the issues for you now?

1 2 3 4 5 6 7 8 9 10

Low

High

What are your goals for therapy?

Is there anything else you would like the intake counsellor to know?