ACCENDO INCEDO MAGNUS (A.I.M.)
INTERNATIONAL INC.
www.aimcounselling.ca

Box 1865
Whitecourt, Alberta T7S 1P6

Ph#: 780- 778-2211
Fax#: 780- 778-2414

A.I.M. International Inc. Client Intake Form

|CONFIDENTIAL|

Welcome to A.I.M. International Inc. Please complete the following information as such information is critical to our assessment and treatment planning.

Name:_____ Date:_____

Address:_____ Town/City:_____

Postal code:_____

Occupation: _____

Work Ph#: _____-_____-_____ Home Ph#: _____-_____-_____

Cell Ph#: _____-_____-_____ Please check where messages can be left:__wrk __ hm __cell

Email address:_____

Please circle: Male or Female Age:_____ Date of Birth :_____/_____/_____(mm/dd/yy)

Place of birth:_____

Emergency contact:_____ Relationship to you:_____

Work Ph#: _____-_____-_____ Cell Ph#:_____-_____-_____

BILLING INFORMATION

Company:_____

Please circle one: Employee or Dependent

If a Dependent, please give Employee's name:_____

Employee Assistance Company:_____

If you work for West Fraser (Blue Ridge Lumber) please circle one : MDF Sawmill

If you work for Millar Western please circle one: Pulp Sawmill

REFERAL INFORMATION

Please tell us how you heard about A.I.M. (circle all that apply)?:

A.I.M. website Facebook You-Tube Friend Co-worker Newspaper Office Window Other

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COUNSELLING HISTORY

Have you had previous counseling? YES NO

If yes, please list who you received counseling from and for how long:_____

_____

_____

Reason for stopping: _____

_____

_____

Do you feel the issue resolved was resolved? Why or why not?_____

_____

_____

MEDICAL HISTORY

Name of current Physician:_____ Location:_____

Relevant medical issues:_____

_____

_____

_____

_____

_____

Please list your current medications with the drug name(s) and length of time you have been using the medication(s):_____

_____

_____

_____

_____

Have you ever been diagnosed with a mental illness Yes No

Diagnosis: _____

_____

_____

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Have you ever had a psychiatric assessment? Yes No Psychiatrists' name:_____

Findings:_____

_____

ALCOHOL, DRUG and FOOD USE

Are you concerned about your alcohol and/or drug use? YES NO

Are others concerned about your alcohol and/ or drug use? YES NO

Do you have difficulty managing your alcohol and/or drug use? YES NO

Have you experienced negative consequences as a result of your use? YES NO

If yes, please describe in detail the effects the use has had on your life:_____

_____

_____

_____

_____

Have you ever suffered from an eating disorder? YES NO

If yes, can you please describe how it arose?_____

_____

_____

Have you received treatment for the disorder (i.e. when, where and from whom)?_____

_____

_____

What is the current status of your eating disorder (i.e. in maintenance, actively gaining weight etc.)?_____

_____

_____

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SUBSTANCE USE

Please mark a "x" beside the substance(s) being used below as either recreational or addiction. Describe the pattern in which you are using them (i.e. for stress relief, insomnia, anxiety relief etc.) If the substance does not apply to you simply write N/A.

SUBSTANCE	Recreational? (Using – No Dependency)……..	Addiction? (Using to gain something……)	Pattern of use
Alcohol			
Cocaine			
Cannabis			
Sugar			
Prescription medications (please list the names)			
Screen Time			
Sex			
Tobacco			
Other, please specify			

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RELATIONSHIP INFORMATION

Please check one: Single _____ Divorced_____ Married _____ Widowed _____ Dating _____

If single, move to the next section please, if not continue below.

Please rate your current relationship out of 10 (with 10 being amazing and 1 being terrible):_____ /10

What needs to happen to increase your rating? _____

_____

_____

HOME SITUAITON

If applicable, please fill out the following information regarding your child(ren) and indicate if they are living at home with you.

Name Sex(F/M) Age Biological or Stepchild Living at home?

_____

_____

_____

_____

_____

Do others live in the household? Yes No If yes, what is their relationship to you?_____

_____

_____

Please briefly describe the problem(s) for which you seek counseling assistance:_____

_____

_____

_____

As a result of counseling what are your hopes? _____

_____

_____

_____

Is there any other relevant information A.I.M. should be aware of? Any other questions you have?

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A.I.M. International Inc. Symptom Checklist

Please place a check mark under the ranking that BEST describes you for each statement.

Name:_____ Date: ____/_____/_____ __
(mm/dd/yyyy)

Statement	Never	Rarely	Occasionally	Frequently	Always
Hyper- vigilance (being on guard at all times)					
Intrusive imagery or flashbacks					
Extreme sensitivity to light and sound					
Hyperactivity					
Exaggerated emotional and startle responses					
Nightmares and night terrors					
Abrupt mood swings					
Reduced ability to deal with stress					
Difficulty falling or staying asleep					
Panic attacks or anxiety					
Difficulty concentrating					
Avoiding certain places or circumstances					
Attraction to dangerous situations					
Frequent crying					
Exaggerated or diminished sexual activity					
Inability to love, nurture or bond with others					
Fear of dying or having a shortened life					
Fear of going crazy					
Inability to make commitments					
Chronic fatigue or very low physical energy					
Headaches					
Neck and back problems					
Asthma					
Digestive problems, colitis, spastic colon					
Depression, feeling of impending doom					
Feelings of detachment, alienation & isolation					
Need for alcohol or drugs to relax					
“Spaciness” or mental blankness					
Reduced ability to formulate plans					
Feelings of helplessness					
Freezing or immobility response to danger					