

Counselling intake form template

A first-session form for individual clients, with a couples version.

What this is

A ready-to-edit intake form for the first session. It collects the details and history you need for a complete record: contact and emergency details, medical aid information, what brought the client to you, their history, and a short set of safety questions. Part A is for individual clients. Part B is for couples and premarital clients, and is built so that each partner answers the personal and safety questions privately.

How to use it

- Replace every highlighted [placeholder] with your own details and delete anything you do not need. Collect only what you will use.
- Send the form before the first session, or hand it over in the waiting room, and read it before the client walks in.
- For couples, print Part B2 and Part B3 once for each partner. Each partner completes them alone and hands them to you directly, not to the other partner.
- Delete this page and the last page before you give the form to clients.

Before you use it

A form is not a risk assessment. If a client answers yes to any safety question, talk about it in the session. A structured tool can help you follow up, such as the Columbia Suicide Severity Rating Scale, which is free to use and comes with free training.

This form collects history, not diagnoses. It supports the record the Council expects. Add the diagnostic questions your scope of practice allows.

Check the medical aid fields with a billing practitioner or your scheme administrator, so they match what your claims need.

Pair it with a consent form and keep both in the client record.

What we checked

- Health Professions Council of South Africa, Keeping of Patient Records, Booklet 9 (September 2016): the record must include identifying details, bio-psychosocial history and allergies, the date, time and place of each consultation, and informed consent. [Booklet 9](#)
- Bradford (2010), screening couples for intimate partner violence: about half of couples seeking therapy report a violent incident in the past year, so partners are asked about safety separately. [Utah State University](#)
- Columbia Suicide Severity Rating Scale, free to use with free training. cssrs.columbia.edu
- Protection of Personal Information Act, section 32: health practitioners may process health information needed for treatment and for running the practice. [Werksmans summary](#)

Last checked: 2 October 2026. General information only, not legal or professional advice. Not approved or endorsed by the Health Professions Council of South Africa.

[Practice name]

[Practice address] · [Telephone] · [Email]

Client intake form

Please complete as much as you are comfortable with. You can leave anything blank and we can talk about it in the session. What you write here is confidential, as set out in your consent form.

Part A. Individual client

1. About you

Full name	Name you prefer to be called		
Date of birth	Identity number	Language you prefer for sessions	
Gender (in your own words)	Marital or relationship status		
Cell number	Email address		
Home address			
Occupation or studies	Who lives with you?		

Is it safe to contact you in these ways?

Phone call	☐ Yes	☐ No
Voicemail	☐ Yes	☐ No
WhatsApp or text message	☐ Yes	☐ No
Email	☐ Yes	☐ No

2. Emergency contact

Name	Relationship to you	Phone number
May I contact this person if I am worried about your safety?		☐ Yes ☐ No

3. How you will pay

- ☐ I will pay privately.
- ☐ I will use my medical aid.

Medical aid scheme	Plan or option	
Main member name	Main member identity number	
Membership number	Dependant code	Client is the main member?

Please bring your medical aid card to your first session.

4. How you found me

- ☐ Internet search ☐ Social media ☐ Doctor or other professional ☐ Friend or family ☐ Medical aid list ☐
- Other: _____

Name of the person or professional who referred you (if any)

May I contact your referrer to let them know you have started?

☐ Yes ☐ No

5. What brings you here

In your own words, what would you like help with?

How long has this been going on, and what has happened recently?

What would you like to be different after counselling?

6. Counselling history

Have you had counselling or therapy before?

☐ Yes ☐ No

If yes: when, with whom, and what was helpful or not helpful?

7. Health

Your doctor's name

Doctor's phone number

Medical conditions you are being treated for

Medication you currently take (name and dose)

Allergies

Do you have trouble sleeping?

☐ Yes ☐ No

Has your appetite or weight changed a lot recently?

☐ Yes ☐ No

Have you ever been admitted to hospital for emotional or mental health reasons?

☐ Yes ☐ No

Has anyone in your family had serious emotional or mental health difficulties?

☐ Yes ☐ No

How often do you use these?

	Never	Now and then	Weekly	Daily
Alcohol	☐	☐	☐	☐
Cigarettes or vaping	☐	☐	☐	☐
Other drugs or non-prescribed medication	☐	☐	☐	☐

8. Your life and support

Who or what supports you? What are you good at or proud of?

What is difficult in your life right now (for example work, money, family, grief, relationships)?

9. Safety and wellbeing

These questions help me look after you. Your answers stay confidential, except as described in your consent form. Please answer as honestly as you can.

- In the past two weeks, have you felt hopeless or that things will not get better? ☐ Yes ☐ No
- Have you had thoughts of harming yourself? ☐ Yes ☐ No
- Have you had thoughts that you would be better off dead, or of ending your life? ☐ Yes ☐ No
- Have you ever tried to harm yourself or end your life? ☐ Yes ☐ No
- Have you had thoughts of harming someone else? ☐ Yes ☐ No
- Do you feel safe at home and in your close relationships? ☐ Yes ☐ No
- Is there anything else about your safety you would like me to know?

10. Declaration

I confirm that the information above is correct as far as I know. I understand I can add to it or correct it at any time.

Name (print)

Signature

Date

For the practitioner

Date received: [date] · Safety answers reviewed with the client: ☐ yes · Follow-up needed: ☐ no ☐ yes: [note]

[Practice name]

[Practice address] · [Telephone] · [Email]

Couples intake form

For couples and premarital clients. Part B1 is completed together. Parts B2 and B3 are completed by each partner alone, in private.

Part B. Couples and premarital clients

B1. About your relationship (complete together)

Partner 1 full name

Partner 2 full name

Date of birth

Date of birth

Cell number

Cell number

Email

Email

Our relationship:

☐ Dating ☐ Living together ☐ Engaged (wedding date: _____) ☐ Married ☐ Separated ☐ Other:

How long have you been together?

How long have you lived together?

Children (names and ages)

Medical aid scheme and main member (if you will use your medical aid)

Membership number

What has brought you to counselling now?

What do you appreciate most about your relationship?

What do you hope will be different after counselling?

Have you had couples counselling before?

☐ Yes ☐ No

Have you both agreed to come?

☐ Yes ☐ No

B2. About you (each partner completes this alone and in private)

Please hand this page directly to your counsellor. Do not share it with your partner. Ask your counsellor how private information is handled in joint sessions.

Your name

Date

In your own words, what is the biggest difficulty in your relationship?

When you disagree, what usually happens? What do you do, and what does your partner do?

What do you most need from your partner that you are not getting?

What do you think your partner would say you could do differently?

On a scale of 1 to 10, how committed are you to making this relationship work? (1 is not at all, 10 is completely)

1 2 3 4 5 6 7 8 9 10 Your answer: _____

Have you thought about ending the relationship in the past six months?

☐ Yes ☐ No

Is there something important that your partner does not know and that you feel unable to say in front of them? (Your counsellor will explain how this is handled.)

☐ Yes ☐ No

Your doctor's name

Medication you take

Allergies

Do you drink alcohol or use other substances in ways that worry you or your partner?

☐ Yes ☐ No

Are you currently receiving treatment for your own emotional or mental health?

☐ Yes ☐ No

B3. Safety (each partner completes this alone and in private)

These questions are asked of everyone who comes for couples counselling. Please answer alone and hand this page to your counsellor yourself. **Do not leave it where your partner can see it.**

- Do you ever feel afraid of your partner? ☐ Yes ☐ No
- Has your partner ever hurt you, pushed you, or thrown or broken things during an argument? ☐ Yes ☐ No
- Has your partner ever threatened you, or threatened to harm themselves if you leave? ☐ Yes ☐ No
- Does your partner control your money, your phone, who you see or where you go? ☐ Yes ☐ No
- Have you ever hurt or threatened your partner, or lost control during an argument? ☐ Yes ☐ No
- Will you feel safe going home today after this session? ☐ Yes ☐ No
- Is there anything else about your safety that your counsellor should know?

The safest way for me to contact you: ☐ Phone call ☐ WhatsApp or text ☐ Email ☐ Only at sessions **Can anyone else see your messages?** ☐ Yes ☐ No

If you are in danger now, call the police on 10111 or the Gender-Based Violence Command Centre on 0800 428 428 (24 hours).

Name (print)

Signature

Date

INTAKE AND CONSENT FORMS

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- **Medical aid details feed your invoices**, so you enter them once and they are there when you bill.
- **A thirty-second scan** of the profile before each session and you are fully oriented.

See Intake and consent forms →

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Built by Sumarie Engelbrecht, a Registered Counsellor in active practice in Mbombela, for South African psychologists and Registered Counsellors.