



**CARRIE WATSON** MSW, RSW

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**COUNSELLING • THERAPY • EATING DISORDERS TREATMENT**  
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**Intake Form**

Please complete this form as accurately as possible and return prior to our first session. This information will help me to prepare for our first meeting. All information will be kept private and confidential.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Please list contact phone numbers and whether or not a message can be left at each number.

Home: \_\_\_\_\_ Messages? Y/N

Work: \_\_\_\_\_ Messages? Y/N

Cell: \_\_\_\_\_ Messages? Y/N

Emergency contact: \_\_\_\_\_ Contact's relationship to you: \_\_\_\_\_

Phone number: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Referred by: \_\_\_\_\_

Please briefly describe the issue(s) that has prompted you to come for counselling:

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What are your goals for working with me? \_\_\_\_\_

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Please include any other information you feel would be useful for me to know about you to better provide the support that you need (use back of page if needed): \_\_\_\_\_

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