SECTION I: CLIENT INFORMATION

Name _____ Date of Birth, Age _____

Address _____ City, Postcode _____

What is the best way for me to contact you?

_____

_____

(Please note, email is not considered a confidential means of communication)

May I leave a message? Yes ○ No ○

May I identify myself as a counsellor? Yes ○ No ○

SECTION II: FAMILY INFORMATION

Are you currently:

single ○, married ○, divorced ○, widowed ○, in a committed relationship ○.

Describe your relationship with your spouse or significant other:

Do you have children? Yes ○ How many? ____. No ○.
If yes, what is your relationship like with your children?

How would you describe your childhood home environment?

Please describe any specific circumstances that affected you as you were growing up?

Does anyone in your family suffer from any psychological, emotional, or physical health problems?

Who do you count on for support?

SECTION III: LIFESTYLE AND PERSONAL INFORMATION

Occupation:

Exercise Level:
Do you exercise regularly Yes ○ No ○ How Often?

Faith Tradition:
What spiritual or religious issues are important to you? How does your culture, heritage, etc, influence you?

Substance Use:
What has been your personal history and experience with prescription drugs, recreational drugs, over the counter medications, alcohol, nicotine, caffeine, food, etc?

Other:
Have you, or anyone else, ever been concerned that you may have experienced any of the following?

Emotional abuse_____ Physical abuse_____ Sexual abuse_____

Sexual assault_____ Eating disorder_____ Addictions _____

Have there been any recent changes in your situation/habits/health/family? Yes ○ No ○

If yes, please explain:

SECTION IV: RISK ASSESSMENT

Suicide:

Have you ever had feelings or thoughts that you didn't want to live? Yes ○ No ○

If (yes), please answer the following:

- How often do you have these thoughts?

- When was the last time you had thoughts of suicide?

- Have you ever attempted suicide?

Harm:

Do you ever think about hurting yourself? Yes ○ No ○

Do you ever think about hurting another person? Yes ○ No ○

Are you ever afraid for your own safety? Yes ○ No ○

SECTION V: MEDICAL and PSYCHOLOGICAL HISTORY

Medications Used:
Please list all medications, including over the counter drugs, you have taken in the past six months.

Medication Name	Daily Dosage	Date

History of hospitalization, surgeries, medical conditions:

Psychological Support:
Have you ever had treatment by a psychiatrist, psychologist, therapist, or counsellor, or been in a support group? Yes ○ No ○ If yes, when:

What was the reason?

What was your experience like?

SECTION VI: DESCRIPTION OF CURRENT CONCERNS

What are the current concerns that you would like to discuss in counselling?

How long has this been a concern for you?

How would you describe the severity of the problem at this time?

How long do you think these changes will take?

What would you like to work on or see changed as a result of counselling: (e.g. Goals for Counselling)

1.

2.

How long do you think these changes will take?

What are your strengths? (Abilities, resources, employment, personality, feelings,habits, relationships)

Is there anything else you would like me to know?

What do you think a therapist should be like?