Confidential Client Information Form

DATE:_____

NAME:_____

ADDRESS:_____

CITY:_____ PROV:_____ POSTAL CODE:_____

GENDER:_____ DATE OF BIRTH: ____/____/____ AGE:_____
MONTH DAY YEAR

ETHNICITY:_____

PHONE 1:_____ Ok to leave a msg? YES NO

PHONE 2:_____ Ok to leave a msg? YES NO

Email address:_____

Appointment reminders will be sent by email

Would you be interested in joining my mailing list to receive information that might be helpful to your particular situation? YES NO

HAVE YOU EVER BEEN TO COUNSELLING BEFORE? YES NO

DO YOU BELIEVE COUNSELLING WILL HELP YOU?

I----------I----------I Please Circle

STRONGLY DISAGREE NEUTRAL STRONGLY AGREE

BRIEFLY DESCRIBE YOUR REASON FOR SEEKING COUNSELLING:

_____

_____

WHAT DO YOU HOPE TO ACHIEVE WITH COUNSELLING?

_____

_____

_____

HAVE YOU EVER: *If yes, describe*

Been diagnosed with a mental illness?.....

Had substance abuse/dependence issues?.....

Been in a motor vehicle accident?.....

Had any work / sports injuries?.....

Been physically / sexually abused / assaulted?.....

Been discriminated against?.....

Been hospitalized / had surgeries?.....

Had a major illness?.....

Had a disturbing medical experience?.....

Had near drowning incidents?.....

Had near death experiences?.....

Please list any medications you are currently taking:

_____

_____

_____

Please indicate **all** symptoms you are currently experiencing and/or find troublesome or disturbing. CHECK the symptoms that cause you the most distress

ANXIETY	ANGER / RAGE	DEPRESSION
PANIC ATTACKS	GUILT	NUMBNESS
EASILY STARTLED	SHAME	HELPLESSNESS
FEARFULNESS	GRIEF / LOSS	HOPELESSNESS
IRRIATABILITY	PHOBIA_____	FATIGUE / LOW ENERGY
LOSS OF CONTROL	LOW SELF ESTEEM	FEELING STRESSED OUT
HYPERACTIVITY	ABRUPT MOOD SWINGS	FEELING SPACED OUT
FORGETFULNESS	SUICIDAL THOUGHTS /	FEELING OUTSIDE YOUR
TREMBLING /	IDEATION	BODY
BODY SHAKES	RESTLESSNESS	FEELING THINGS ARE
OBSESSIVE THOUGHTS /	BEHAVIOURS	NOT REAL
INABILITY TO FOCUS / CONCENTRATE		THINKING "THIS IS NOT ME"
SLEEPING PROBLEMS	NAUSEA	HEADACHES / MIGRAINS
NIGHTMARES	CHANGE IN APPETITE	STOMACH ACHES
FLASHBACKS	CLENCHING OF JAW	CHRONIC PAIN
DIZZINESS / FAINTING	MEMORY LOSS	SHORTNESS OF BREATH