The information you provide on this form will not be disclosed to anyone (including those who may attend counselling with you), and will be kept as part of your confidential file. It is not required that you answer all the questions; however, your thorough completion of the questionnaire is strongly encouraged. Your responses will enable me to make a more thorough, focused assessment and support more efficient treatment planning.

Date for First Counselling session: _____

GENERAL INFORMATION

Name: _____

Age: _____ Date of Birth_____

Address:_____

Home Phone: _____(May we leave a message for you here? □ yes □ no)

Cell Phone: _____(May we leave a message for you here? □ yes □ no)

Employer:_____

Occupation:_____

Are you content in/with your current employment?

□ very □ moderately □ very little □ not at all □ not sure

Work Phone: _____(May we leave a message for you here? □ yes □ no)

Preferred Email Address:_____(May we contact you here? □ yes □ no)

If contact is necessary (for appointments, etc.) which number:

□ home □ work □ cell □ other_____

Last year of school completed: 9 10 11 12 GED College/University: 1 2 3 4 Graduate: 1 2 3 4 5 6

Certificate/Diploma/ Degree pursued/accomplished

_____

RELATIONAL INFORMATION

Current Relationship Status: □ single □ exclusively dating □ engaged □ married □ common-law

□ separated □ divorced □ widowed (check all that apply)

If in committed relationship, for how long? _____

How long have you known your partner? _____

Partner's Name: _____ Partner's Age: _____

Number of previous marriages for you? _____ For your partner? _____

If widowed, separated, or divorced, for how long? _____

With whom do you currently live? □ Alone □ Spouse □ Children □ Parent(s) □ Sibling(s)

□ Boyfriend □ Girlfriend □ Other (please specify)

_____(check all that apply)

If you have children, how many? _____ and how old _____

PHYSICAL HISTORY

Please list any conditions, illnesses, treatments, or surgeries (including pregnancies, or related treatments) that might be relevant to your reason for seeking counseling:

_____

_____

_____

Please list all current medications you are taking, and the reasons. (List even if you seldom use, or take only as needed.)

medication:_____ dosage:_____ since:_____
reason:_____
medication:_____ dosage:_____ since:_____
reason:_____
medication:_____ dosage:_____ since:_____
reason:_____
medication:_____ dosage:_____ since:_____
reason:_____
medication:_____ dosage:_____ since:_____
reason:_____

PRESENTING ISSUES AND GOALS

Please describe briefly why you are coming to counselling? (i.e., what are your issues, problems?)

_____
_____
_____
_____
_____
_____
_____
_____

What do you hope to gain or change by coming for counselling?

_____
_____
_____
_____
_____
_____
_____

How long do you believe counselling should last?

_____

Have you had any previous counseling, psychiatric treatment, or residential/in-patient care?
 no yes.

Please indicate on the scale below how distressing your problem(s) are to you. Place an "X" on the line.

_____

Slightly Distressed Moderately Distressed Extremely Distressed

Are you currently experiencing any suicidal thoughts? Yes No

Over the past several years, have you frequently experienced suicidal thoughts? Yes No

Have you attempted suicide in the past? Yes No If yes, when?_____

Have any of your friends or family ever committed or attempted suicide? Yes No