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COUNSELLING | PSYCHOTHERAPY | YOGA
902-240-9642

PERSONAL INFORMATION

NAME(S) ______________________________

ADDRESS ______________________________

POSTAL CODE ______________________

PHONE NUMBERS (HOME) ________________ (CELL) ________________

IS IT OK TO LEAVE A MESSAGE? (CHECK ONE) ☐YES ☐NO

DATE OF BIRTH ______________________

EMAIL ADDRESS (if desired) ______________________________

FAMILY SITUATION

☐Married ☐Single ☐Widowed

☐Partner ☐Separated ☐Foster/Adoptive family

☐Divorced ☐Blended ☐Son/Daughter

☐Children(names) ______________________________

HAVE YOU CONSULTED A THERAPIST BEFORE? ☐YES ☐NO DATES: ____________

REASONS FOR SEEKING A THERAPIST ______________________________

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IN THE PAST, WHAT HAVE YOU TRIED TO HELP YOUR SITUATION? ____________

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HOW DID YOU FIND OUT ABOUT MY SERVICES? ______________________________

PERSONAL HISTORY

PLEASE CHECK ANY OF THE FOLLOWING THAT ARE CONCERNS FOR YOU:

- ☐ Alcohol use
- ☐ Internet/Computer use
- ☐ Stress
- ☐ Anger/Irritability
- ☐ Suicidal thoughts/attempts
- ☐ Self-esteem
- ☐ Drug use
- ☐ Finances/Debt
- ☐ Relationship difficulties
- ☐ Anxiety/Panic
- ☐ Sleep difficulties
- ☐ Family conflict
- ☐ Gambling
- ☐ Eating/Body Image
- ☐ Loss/Grief
- ☐ Depression/Low Mood
- ☐ Work difficulties
- ☐ Sexual difficulties
- ☐ Other(please specify) ______________________________

ARE YOU NOW OR HAVE YOU EVER BEEN EXPOSED TO:

Physical Violence	☐ Current	☐ Past	☐ Not Applicable
Emotional/Verbal Abuse	☐ Current	☐ Past	☐ Not Applicable
Sexual Abuse	☐ Current	☐ Past	☐ Not Applicable
Workplace Harassment	☐ Current	☐ Past	☐ Not Applicable
Family Addictions	☐ Current	☐ Past	☐ Not Applicable
Accident/Trauma	☐ Current	☐ Past	☐ Not Applicable

Other frightening or overwhelming experiences (please describe below)

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DO YOU CONSULT A FAMILY DOCTOR? ☐ YES ☐ NO

PLEASE LIST ANY MEDICAL DIAGNOSES OR HEALTH CONDITIONS: ______________________________

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PLEASE LIST ANY MEDICATIONS YOU CURRENTLY TAKE: ______________________________

____

OTHER INFORMATION: ______________________________

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