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# CLIENT INFORMATION FORM

***Please use this form to tell me about yourself. Fill in only those areas that you are comfortable with.***

**Today's Date:** (dd / mm / yyyy) _____

## Information about You

**Given Names** _____ **Last Name** _____
**Date of Birth** (dd / mm / yyyy) _____ **Age** _____
**Gender** _____ **Marital Status** _____
**Street Address** _____ **City** _____
**Postal Code** _____
**Telephone (Home)** _____ **Tel (Work)** _____

**Issue/Symptom Checklist. Fill in: 0 – none, 1–mild, 2–moderate, 3–severe.**

| | | |
|---|---|---|
| ___ marriage | ___ divorce/separation | ___ addictions |
| ___ God / faith | ___ pre-marital | ___ child custody |
| ___ disabled | ___ grief / loss | ___ past hurts |
| ___ sexual issues | ___ work / career | ___ depression |
| ___ codependency | ___ family | ___ school |
| ___ fear / anxiety | ___ intimacy | ___ children |
| ___ money / budgeting | ___ anger / control | ___ communication |
| ___ parents | ___ aging / dependency | ___ loneliness |
| ___ self-esteem | ___ in-laws | ___ weight control |
| ___ mood swings | ___ stress control | ___ worry |

___ other (specify) _____

**Reason for seeking counselling at this time:**

**What is/are your most difficult emotion/s right now (e.g. anger, sadness, fear)?**

**When do you most often experience these emotions?**

**What would you like to be different in your life at this time?**

**How can counselling help you reach this goal?**

**Any current or past suicidal thoughts, feelings or actions?**
**Y _____ N_____ If yes, please explain:**

**Any past problems, hospitalizations, or jailings for suicidal or assaultive behavior?**
**Y_____ N_____ If yes, please explain:**

**Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Y _____ N_____ If yes, please explain**

## Medical Information

**Family Doctor Name _____ Phone _____**

**Are you presently taking any medication?**
**Y____ N ____ If yes, please specify the name and purpose of the medication:**
**Any challenges with eating _____ sleeping _____ chronic pain _____ recent weight changes _____? Describe any answers checked above.**

**Any other medical issues?**

## Family Information

| Name | Relationship | Age |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Is there any past or present mental health issue (e.g. depression, schizophrenia, bi-polar, personality) in your present family or family of origin?**

**Have you or a family member ever been hospitalized for mental or emotional health concern? Y____ N ____ If yes, please explain – dates, where, reason:**
_____
_____

**Is there any past or present addictive behavior (alcohol, drugs, gambling, food, other) in your present family or in your family of origin?**

**Any other information you wish to add:**

## Emergency Contact Information

**Contact Person _____**
**Street Address _____ City _____**
**Postal Code _____**
**Telephone (Home) _____ - _____ Tel (Work) _____ - _____**
**Relationship to you _____**

***I hereby give permission for Steven Abma (Psychotherapist) to contact the above person in the event of an emergency.***

_____ _____
Client's Signature Date