**CLIENT INFORMATION**

**NAME:**

**DOB: AGE: MALE/FEMALE/OTHER**

**COUNTRY OF BIRTH: ETHNICITY:**

**OCCUPATION:**

**ADDRESS:**

**PHONE: EMAIL:**

**EMERGENCY CONTACT NAME:**

**EMERGENCY CONTACT PHONE:**

**RELATIONSHIP TO YOU:**

**CHILDREN: No Yes**

**If yes, please provide names and ages**

**HOME Who do you live with?**

**TREATMENT HISTORY**

Are you currently receiving psychiatric services, psychotherapy or counselling elsewhere?

no yes (reason for treatment)

Have you had previous psychotherapy/counselling?

no yes (reason for treatment)

Are you currently taking prescribed psychiatric medication (anti-depressants or others)?

no yes

If yes, please list:

|  |
| --- |
| **Have you ever experienced any of the following?** |
| Extreme depressed mood | No • | Yes • | Recently |
| Dramatic mood swings | No • | Yes • | Recently |
| Rapid speech | No • | Yes • | Recently |
| Extreme anxiety | No • | Yes • | Recently |
| Panic attacks | No • | Yes • | Recently |
| Phobias | No • | Yes • | Recently |
| Sleep disturbances | No • | Yes • | Recently |
| Hallucinations | No • | Yes • | Recently |
| Unexplained losses of time | No • | Yes • | Recently |
| Unexplained memory lapses | No • | Yes • | Recently |
| Alcohol/substance abuse | No • | Yes • | Recently |
| Frequent body complaints | No • | Yes • | Recently |
| Eating disorder | No • | Yes • | Recently |
| Body image problems | No • | Yes • | Recently |
| Repetitive thoughts (e.g. obsessions) | No • | Yes • | Recently |
| Repetitive behaviours (e.g. frequent checking, hand washing) | No • | Yes • | Recently |
| Homicidal thoughts | No • | Yes • | Recently |
| Suicide attempts If yes, when? | No • | Yes • | Recently |

**What are your Goals for Therapy?**