

	Client	Sex: F M	DOB:	Age:
Identifying Information	Date of 1 st Call:			
	Surname:		First Name:	
	Address:			
	City:		Postal Code:	
	Phone	Home Cell Work		Home Cell Work
	Email:			
	PARTNER	Sex: F M	DOB:	Age:
	Surname:			
	First Name:			Initial:
	Address:			
	City:		Postal Code:	
	Phone	Home Cell Work		Home Cell Work
	Email:			
	CHILDREN	M F	Age	Parent
Status: Single Married Common-Law Blended Separated Other, describe:				
Length of Present Relationship:				
Office Use Only	Preferences: evening day. Other:			
	Date of Initial Session:		Therapist:	
	PP:			
	File Closed:		Reason:	

Doctor/Emergency Cont.	Primary Family Doctor:	Phone:
	Address:	
	City:	Postal Code:
	Medical Conditions:	
	Current Medications:	
	Can we contact your doctor with updates? YES NO _____	
	Signature	
	Local Emergency Contact:	
	Relationship:	Phone:
Counselling Hx	Have you ever been in counselling before? Yes No	
	If yes, for what and when?	
Mental Health	Do you have a family history of:	
	Mental Health Issues – e.g. depression Serious Illness Chemical Dependency If yes, please explain:	
Referral Source	How did you find me?	
	Internet - Search Engine: _____ Keywords: _____ Other Website Ad – Name of Website: _____ Word of mouth – Name of person who referred you: _____ Doctor – Name of Doctor _____ Telus Yellow Pages – What did you look under? _____ Other – Please describe:	
Contact Log		