Background Information

General Information:	
Full Name	
Address	
Phone Number(s)	
Date of Birth	
Emergency Contact Name and Number	
What is your occupation and how long have you been in this position?	
Marital Status / Length of Relationship?	
Partner's Name & Occupation	
Do you have children? Name(s) and Age(s)	
Family Physician Name and Number	
Last Examination Date?	
How would you like to receive appointment confirmations and reminders? Email or Telephone Message? Indicate best number and/or email to use	
We can do direct billing for some extended health companies. If you have extended health coverage please provide all necessary information. Company / Plan Number / Policy Number etc.	

Medical History:	
Do you currently have any medical / physical / health issues to report?	
Current Medications	
Any previous major medical issues (head injury, MVA, surgery)	
Do you currently use street drugs or alcohol?	
If yes, please describe – Type / Frequency / Increase or decrease from the past	
Have you ever been treated for alcohol or drug use? If yes, name facility / program	
Are there any issues of addiction in your family? If yes, describe	
What is your current daily caffeine intake? Include coffee, tea and pop	
Have you ever received psychiatric, psychological or counselling assistance before? If yes, please indicate dates / clinician / reason	
Have you ever taken psychiatric medication of any kind before? If yes, indicate dates / prescribing physician / type / reason	
Have you ever made any suicide attempts / self-destructive behavior / violent behavior? If yes, indicate dates / description / outcome	
Any issues of mental health illness in your family? If yes, describe	
Why are you seeking therapy?	
Is there anything I should know about?	

Please circle any of the following you feel you are struggling with right now:

Depression	*Fears*	*Tiredness*	*Nervousness / Anxiety*
Suicidal Ideation	*Finances*	*Drug Use*	*Separation /Divorce*
Friends	*Anger*	*Self-Control*	*Sleep*
Appetite	*Work*	*Relaxation*	*Headaches*
Loss	*Memory*	*Ambition*	*Remembering the Past*
Insomnia	*Loneliness*	*Making Decisions*	*Inferiority Problems*
Concentration	*Education*	*Hurting Others*	*Health Problems*
Temper	*Nightmares*	*Unhappiness*	*Marriage / Relationship*
Too Much Energy	*Panic Attacks*	*Trying to Lose Weight*	*Children / Parenting*
Stress	*My Thoughts*	*Flashbacks*	*Avoiding People / Places*
Guilt	*Physical Pain*	*Low Energy*	*Changes in my Life*
Alcohol Use	*Self-Harm*	*Shyness*	*Sexual Problems*
Body Image	*Career Choice*	*Trauma / Abuse*	*Difficulty Trusting*
Disability	*Grief*	*Legal Matters*	*Sense of Unreality*
Cleanliness	*On-Guard*	*Hearing Voices*	*Checking Rituals*
Work	*Identity – Self*	*Identity – Partner*	*Family Relationships*