Confidential Client Information Form

Welcome to Abma Counselling Services. We want to make the most of each appointment that you have with us. Please use this form to provide your therapist with some basic information before your first appointment. **The information is confidential and will not be shared with anyone without your written consent.** If you do not wish to fill out any areas of this form, feel free to leave it blank.

Contact Information:

Full Name:_____ Age: _____ DOB: _____

Address: _____ City: _____ Prov:_____

Postal Code: _____

Home Phone:_____Cell : _____ text message ok? Y/N

Email address:_____

Emergency Contact:

Person to alert in the event of a medical emergency: _____

Relationship to you:_____Phone: _____

Family Doctor: _____ Phone: _____

General Information:

Current Occupation/Studies: _____

Relationship Status (circle one): single married partnered separated divorced widowed

Spouse/Partner name: _____ Age:_____ Years in relationship:_____

Children (name/gender/age): _____

Referral Information:

How did you hear about us?

Were you referred to us by a medical professional? Yes / No

If yes, please provide the medical professional's name and reason for referral.

Medical and Psychological Health Information:

1. Have you ever experienced the following:

Symptom:	Current	Past	Never
Depressed Mood			
Rapid Speech			
Panic Attacks			
Sleep Disturbances			
Unexplained losses of time/memory			
Overuse of Alcohol/Substances			
Eating disorder (binge eating/severe dieting)			
Suicidal thoughts			
Suicide attempt			
Repetitive thoughts (e.g. obsession)			
Repetitive behaviors (hand-washing, checking)			
Mood swings			
Anxiety			
Phobias			
Hallucinations			
Frequent body complaints			
Body image problems			
Loss of sleep			
Social withdrawal			
Loss of appetite			

Have you ever had a concussion?: Yes/No

If so, please note the approximate date and how the concussion occurred in the space below.

2. Do you have any medical conditions that are affecting your daily life: (ex. chronic illness, chronic pain, concussions, traumatic injury, severe allergies, head injuries, surgeries). Please provide dates when possible.

3. Are you currently taking prescription medication? Yes / No
If yes, please provide list of medications and dosages.

4. Have you had previous psychological care or counselling? Yes / No
If yes, please note the approximate date and reason for treatment.

5. Have you ever been hospitalized for psychological difficulty? Yes / No
If yes, please note the date and length of stay.

6. If applicable, please note any addictive behavior (alcohol/substance abuse) in your present family or family of origin.

(turn over)

Reasons for Counselling:

1. What is the nature of the concern that you would like to address in therapy?

2. List any strategies used that have helped address this problem.

3. List any strategies used that haven't helped address the problem.

4. If therapy was helpful, what would you be able to do more effectively?

Is there anything else that you would like to add?