Date: _____

Note: All personal information is held securely in accordance with the appropriate legislation, is confidential and treated appropriately.

Client Information

Full Name _____

Name you like to be called _____

Address _____

_____

Telephone Numbers/Contact Details **OK to leave message?**

Cellphone: _____ _____ Yes _____ No

Alternate phone: _____ _____ Yes _____ No

Email: _____

Preferred Contact Mode: email: Yes/No text: Yes/No phone call: Yes/No

Emergency contact (name and phone number)

_____

Personal Information

Date of Birth _____

Significant Other's Name (if applicable): _____

Names and Ages of Children (if applicable):_____

_____

Occupation_____

Highest level of education completed_____

Name:_____ Date:_____ Client Information page 2

Previous counseling/treatment/hospitalization? Y/N If yes, please provide additional information:

_____

_____

_____

Current medications and dosage:

_____

_____

_____

Any chronic health issues? Y/N

If yes, please describe:

_____

_____

Please list other treating providers (physician, nutritionist, etc), if any:

Name _____ Phone _____

Name _____ Phone _____

History of, or current, self-harm behavior and/or suicidal thoughts/attempts: Y/N

If yes, please describe:_____

Please list current and past alcohol/tobacco/drug use:

Substance:	Average amount and frequency:	Last date of use:
_____	_____	_____
_____	_____	_____
_____	_____	_____