BASIC INFORMATION QUESTIONNAIRE

Please complete this information questionnaire at your earliest convenience.

Client Name: _____ Today's Date: _____

Address: _____

City: _____Postal Code: _____

Home phone: _____ Can leave voicemail? Y / N

Work phone:_____ Can leave voicemail? Y / N

Cell phone:_____ Can leave voicemail? Y / N

Email: _____

Age: _____Birth Date (YEAR/MONTH/DATE): _____

Occupation: _____

Relationship status: ❒ single ❒ married ❒ long-term relationship ❒ separated ❒ divorced ❒ stepfamily ❒ widowed

Number of children: _____ Age of children:_____

Parent information to be completed if client is under 16 years of age:

Mother's / Stepmother's name: _____ Contact #:_____

Mother's / Stepmother's occupation: _____

Father's / Stepfather's name: _____ Contact #:_____

Father's / Stepfather's occupation: _____

Custody arrangement: _____

Grade: _____School:_____

Who referred you? _____ ❒ I was self-referred

Who is your/your child's family physician? _____

Location of physician's office: _____

What kind of counselling or psychotherapy have you/your child had in the past? _____

_____

List any medications you/your child are/is currently taking:_____

_____

List any major health problems you/your child are/is dealing with:_____

_____

_____

Briefly state your reasons for seeking help: _____

_____

_____

_____

Please circle the difficulties or issues that you/your child are/is currently experiencing:

Anxiety	Nervousness	Social Problems	Friends
Panic attacks	Rituals	Worry	Shyness
Nightmares	Trauma	Fear	Relaxation
Sadness	Suicidal thoughts	Self-esteem	Depression
Memory	Concentration	Irritability	Hopelessness
Drug	Alcohol	Sexual problems	Energy level
Self-control	Anger	Performance	Perfectionism
Sleep	Appetite	Pain	Health
Stomach troubles	Nausea	Headaches	Stress
Decision making	Career choice	Legal matters	Family
Divorce	Separation	Education	Work
Children	Parenting	Grief	Sexuality
Feeding	Toileting	Defiant behaviour	Attention
Learning Disability	Development delay	Giftedness	School problems
Binging behaviours	Purging behaviours	Restricting food	Self-harm
Bullying	Harassment	Relationship violence	Interpersonal difficulties
Couple difficulties	Stepfamily adjustment		

At what times over the course of your/your child's life have you/your child dealt with mental illness?

From _____ to _____ What were you/your child dealing with? _____

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From _____ to _____ What were you/your child dealing with? _____

At what age did your/your child's mental health difficulties first begin? _____

When was that last time that you/your child were/was symptom free or felt like your/his/her usual self?

_____

Any other relevant information you feel your therapist should know prior to your first meeting? _____

_____

_____

_____