SARAH ATKINSON, MA, RCC
Pemberton BC
Email: info@sarahatkinsoncounselling.ca
www.sarahatkinsoncounselling.ca

Introduction

Please provide the following information and answer the questions below.

Please note: information you provide here is protected as confidential information.

Please fill out this form and email to the address above. You may wish to encrypt/password protect.

Name: _____

Birth Date: _____ /_____ /_____ Age: _____
d m y

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Transgendered

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (Province) (Postal Code)

Preferred Phone: _____ Alternate Phone: _____

May we leave a message? ☐ Yes ☐ No May we leave a message? ☐ Yes ☐ No

E-mail: _____ May we email you? ☐ Yes ☐ No

*Please note: Email correspondence is <u>not</u> considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No ☐ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

☐ No ☐ Yes, please list: _____
_____

Have you ever been prescribed psychiatric medication?
☐ No ☐ Yes, please list and provide dates: _____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
_____

3. How many times per week do you generally exercise? _____
What types of exercise to you participate in?_____
_____

4. Please list any difficulties you experience with your appetite or eating patterns:
_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?
☐ No ☐ Yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
☐ No ☐ Yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
☐ No ☐ Yes, please describe: _____

8. Do you drink alcohol more than once a week?
☐ No ☐ Yes, frequency & amount: _____

9. How often do you engage recreational drug use?
☐ Daily ☐ Weekly ☐ Monthly ☐ Occasional ☐ Never

10. Are you currently in a romantic relationship?

☐ No ☐ Yes ☐ Infrequently ☐ Never
If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:
_____
_____
_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse:	yes/no	_____
Anxiety:	yes/no	_____
Depression:	yes/no	_____
Domestic Violence:	yes/no	_____
Eating Disorders:	yes/no	_____
Obesity:	yes/no	_____
Obsessive Compulsive Behaviour:	yes/no	_____
Schizophrenia:	yes/no	_____
Suicide Attempts:	yes/no	_____

RISK ASSESSMENT:

Any risk factors present? ☐ No ☐ Yes If yes, specify current risk factors:

Potential for violence:	yes/no
Hostile/ Abusive behaviour:	yes/no
Major Depression:	yes/no
Suicidal Ideation/Intent/Plan:	yes/no

PAST RISK FACTORS

Suicide Attempts:	yes/no
Violent Behaviour:	yes/no
Inpatient Hospitalization:	yes/no
Hostile/Abusive behaviour:	yes/no
Major Depression:	yes/no
Suicidal Ideation/Intent/Plan:	yes/no

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ No ☐ Yes
   If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____