



**Client Information**

Name:

Phone Number:

Email Address:

Address:

Family Doctor:

Emergency Contact:

Have you ever had a diagnosis regarding your mental health, if so what were you diagnosed with?

Are you on any medications that may impact your mental health?

Do you have any medical conditions you feel we should be aware of?

Have you accessed therapy before?

If have accessed therapy in the past what have you found helpful, what did you not find helpful?

What are some of the goals that you have in regards to your counselling?