Mindful Therapy

CONFIDENTIAL CLIENT INFORMATION

Welcome to MindfulTherapy. I am hoping you can make the most of your appointments with us. One way of doing this is to gather essential information in advance of your first appointment. Please, fill out the following as completely as possible. This information is confidential. If you have concerns and wish to leave some parts out, please do so.

First Name: _____ Last Name: _____

Pronouns: She/Her/Hers. He/Him/His

Address: _____

City: _____ Province: _____ Postal Code: _____

Cell/Mobile Phone: _____ Can we leave a message? Yes / No

Email: _____ Can we contact via email? Yes / No

Age: _____ Birthdate:_____ Birthplace: _____

Education: High School: Yes / No. Post Secondary: Yes / No

Current Occupation: _____ Job Satisfaction: Low-------High

Person to notify in case of emergency: _____

Relationship to you: _____ Phone: _____

Family Doctor or Psychiatrist: Phone: _____

Relationship Status: Single. Married. Partnered. Separated. Divorced. Widowed. Other.

Spouse/Partner's name: _____ Age: _____ Yrs in relationship: _____

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Current Occupation: _____ Marital Satisfaction: low--- High

Other significant-close relationships:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Siblings: M/F - Age _____

_____

_____

_____

Children/Dependents/Pets: Name: Birthdate: Age: _____

_____

_____

_____

_____

Parental Marital Status: Married. Separated. Divorced. Widowed. Other

Is mother alive? Y/N

If deceased, please state yr of death: _____ Mother's birthplace: _____ Mother's profession: _____

Your relationship with your mother is best described as:

Close. Somewhat close. Distant. Conflicted.

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Is Father alive? Y/N

If deceased, please state yr of death: _____ Father's birthplace: _____ Father's profession: _____

Your relationship with your father is best described as:

Close. Somewhat Close. Distant. Conflicted.

History of abuse? Physical. Sexual. Verbal/Emotional. Other.

Alcohol use? Never. Occasional. Frequent. Dependent.

Substance (non-medical) use? Never. Occasional. Frequent. Dependent.

Please, check all that may apply to you:

- ☐ Anger/ increased irritability
- ☐ Anxiety attacks
- ☐ Appetite changes
- ☐ Avoidance/Withdrawl
- ☐ Depressed mood
- ☐ Excessive energy
- ☐ Excessive worry
- ☐ Excessive guilt
- ☐ Fatigue
- ☐ Feeling numb
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Inability to enjoy activities
- ☐ Increase in risky behavior
- ☐ Increased or decreased libido
- ☐ Loss of concentration/memory
- ☐ Loss of interest
- ☐ Racing thoughts
- ☐ Sleep disturbances or changes

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Please, describe any other significant past or present medical problems:

_____

_____

_____

Do you have thoughts of self-harm or suicide? Y/N

Have you ever planned suicide or have a history of attempts? Y/N

Current list of medications, both over the counter and prescription.

Medication Date Reason _____

_____

_____

Have you seen a counselor or mental health practitioner in the past? Y/N

If yes, when, duration, and the nature of the issues at the time?

_____

_____

_____

Have you ever been hospitalized for a psychological issue? Y/N

If yes, when and the nature of the problem at the time?

_____

_____

_____

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What are your current life stressors?

_____

_____

_____

What is the nature of the concern you wish to address in your sessions?
It sometimes helps to find words to express your experience in print.

_____

_____

_____

Do you have hopes, wishes, or goals for therapy? Please feel free to share them in this space.

_____

_____

_____