

## Client Registration Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email address: \_\_\_\_\_

Date of birth (dd/mm/yyyy): \_\_\_\_\_ Current Age: \_\_\_\_\_

Phone Number(s) cell: (204) \_\_\_\_\_ Leave Message Y N \_\_\_\_\_

**Emergency Contact:** (name) \_\_\_\_\_

(Relationship) \_\_\_\_\_ (email) \_\_\_\_\_

(Cell Number and address) \_\_\_\_\_

**Credit Card Type & Number:** \_\_\_\_\_

Expiration date and 3 numbers on the back: \_\_\_\_\_

*In the event that you cancel your appointment with less than 24 hours or do not show up for your appointment, your credit card will be charged the **full price of the session**. Otherwise, your credit card will never be used unless you choose to use it as a form of payment which has a 2.65% transaction fee. Please initial that you have read and agree to the above:* \_\_\_\_\_

Are you currently seeing another helping professional (psychologist, counsellor, social worker) for another concern in my life? \_\_\_\_\_

I heard about your services from: \_\_\_\_\_

I decided to come to counselling because: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Things I have tried in the past that have helped: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Goals** I have for counselling (things I'd like to be different in my life): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Resources** (no judgment! This is just information to use in therapy)

1. Do you exercise? How? When? How Often? \_\_\_\_\_

\_\_\_\_\_

2. Do you drink alcohol? If so, what, when, and how often? \_\_\_\_\_

\_\_\_\_\_

3. Do you drink coffee or tea? If so, what, when, and how often? \_\_\_\_\_

\_\_\_\_\_

4. Do you smoke? If so, what, when, and how often? \_\_\_\_\_

\_\_\_\_\_

5. Do you use any drugs to cope? If so, what, when, and how often? \_\_\_\_\_

\_\_\_\_\_

6. Have you ever felt guilt about any of the above? \_\_\_\_\_

\_\_\_\_\_

7. Have you ever noticed that you “tune out” during the day, sometimes lose track of time, feel like you are living someone else’s life in someone else’s body, forget certain times of your life? \_\_\_\_\_

\_\_\_\_\_

**Relationships:**

Status: please circle

Single      married      separated      divorced      dating      common-law      widowed

Are you happy with your status? If not, what would you like to change? \_\_\_\_\_

\_\_\_\_\_

Do you have children? Do they live with you? Please list name and age of each: \_\_\_\_\_

\_\_\_\_\_

**School/Job** \_\_\_\_\_

Are you happy with how you spend your time? If you could change it, what would you like to do? \_\_\_\_\_

\_\_\_\_\_

Any other life stressors? \_\_\_\_\_

**Medical:**

Who is your general practitioner? \_\_\_\_\_

Address and phone number: \_\_\_\_\_

Any relevant medical concerns or medications? \_\_\_\_\_

\_\_\_\_\_

**Previous Psychotherapy:**

Have you ever had previous counselling or other treatment? If so when and by whom? \_\_\_\_\_

\_\_\_\_\_

Have you ever had suicidal thoughts or attempts? \_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalized for psychiatric reasons? \_\_\_\_\_

\_\_\_\_\_

Does your family have a history of mental health issues? \_\_\_\_\_

\_\_\_\_\_

Is there any other relevant background information you wish to share? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_