Safe Harbour
THERAPY

Client Registration Form

Name: _____

Address (inc. postal code): _____

Email address: _____

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

Phone Number(s) cell: ( ) _____ Leave Message Y N _____

Emergency Contact: (name) _____

(Relationship) _____

(Phone numbers and address) _____

Credit Card 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.*

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 practictioner? _____

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?_____

_____

_____