Please provide the following information and answer the questions below. Please note: The information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session. **Please print clearly**.

Name: ____
(Last name) (First name) (Middle name or Initial)

Name of parent/guardian (if you are under 18 years):
____
(Last name) (First name) (Middle name or Initial)

Birth Date: ________ /_______ /_______ Age: _____ Gender: □ Male □ Female
(Month) (Day) (Year)

Address:____
(Apartment/Unit) (House/Building Number) (Street)

____
(City) (Province) (Postal Code)

Home Phone: ____________________ May we leave a message? □ Yes □ No

Cell/Other Phone: ________________ May we leave a message? □ Yes □ No

E-mail: ____
May we email you? □ Yes □ No
***Please note:** E-mail correspondence and cell phone communication are not considered to be confidential media of communication.

Marital Status:
□ Common Law/Partnership □ Married □ Never Married
□ Separated □ Divorced □ Widowed

Please list any children/ages: ________________ ( ) ____________________ ( )

Emergency contact: (A person we can contact in the event of an emergency)

Name: ____
(Last name) (First name) (Middle name or Initial)

Relationship to you: _____________________

Address:____
(Apartment/Unit) (House/Building Number) (Street)

____
(City) (Province) (Postal Code)

Phone: Home ________________ Cell: ________________ Other: ___________

How did you find out about *Rainforest Relaxation Counselling Services*?

____

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 in the past?
□ No □ Yes Please list: _____________________________________

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good Excellent

Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (please circle)
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 If yes, for approximately how long?

____

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

____

7. Are you currently experiencing any chronic pain?
□ No □ Yes If yes, please describe:
____

8. Do you drink alcohol more than once a week?
□No □Yes How often? ___________________

9. How often do you engage recreational drug use?
□Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? No Yes
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, in the space provided please indicate the family member's relationship to you (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	______________________
Anxiety	yes/no	______________________
Depression	yes/no	______________________
Anger	yes/no	______________________
Domestic Violence	yes/no	______________________
Eating Disorders	yes/no	______________________
Obesity	yes/no	______________________
Obsessive Compulsive Behaviour	yes/no	______________________
Schizophrenia	yes/no	______________________
Suicidal talk/Behaviour	yes/no	______________________
Suicide Attempts	yes/no	______________________

ADDITIONAL BACKGROUND 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?

____
____
____