

Children's Name & Ages: _____

Client 1: Employment: _____

Client 2: Employment: _____

Client 1: Education (grade complete, any postsecondary): _____

Client 2: Education (grade complete, any postsecondary): _____

Client 1: Family Doctor's Name & Address: _____

Client 2: Family Doctor's Name & Address: _____

Client 1: Relevant Medical History (please describe any significant current or past medical problems): _____

Client 2: Relevant Medical History (please describe any significant current or past medical problems): _____

Client 1: Past Counselling Yes No When: _____
For: _____

Client 1: Past Counselling Yes No When: _____
For: _____

Have you ever been hospitalized for a psychological difficulty?

Yes _____ Client: _____

No

Type of counselling requested: Personal Couple/ Marriage

Family

Do you have insurance or employee assistance coverage? Yes No,
Client _____

If yes, you may want to determine the number of sessions covered or the
maximum payable per year and the method of reimbursement.

Emergency Contact: _____ Number: _____
Relationship to client: _____
