

JEWELL COUNSELLING
CLIENT INFORMATION

Name: _____

Address:

_____ STREET ADDRESS _____ CITY/PROVINCE _____ POSTAL CODE

Primary Phone: _____ Messages? (Yes / No)

Alternative Phone: _____ Messages? (Yes / No)

Email: _____ * Confidentiality Limits

Skype: _____ (online clients)

Age: _____ Date of Birth: _____

Relationship/Marital Status: _____

Anniversary Date : _____

Children:

_____ Age: _____
_____ Age: _____
_____ Age: _____

Emergency Contact: _____

Address: _____

Phone: _____ Messages? (Yes / No)

Relationship to you: _____

2nd floor, 1511 10 Street SW, Calgary, AB T2M 3Y7

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Physician: _____

How did you get my name: _____

If online, what search words did you use:

Education / Work / Military / Hobbies:

If you are currently going to school, where? What are you studying? _____

High School degree? Year graduated _____ OR GED? Year obtained _____

Other education and degrees including trade schools:

School / Degree	Focus of Study	Year Completed / Graduated
_____	_____	_____
_____	_____	_____
_____	_____	_____

Occupation: _____ How Long? _____

Place of Employment: _____ How Long? _____

City/State: _____

If not employed, how long has it been since you worked? _____

What kind of job did you have? _____

What caused you to stop working? _____

What other types of work have you done in the past? _____

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Have you ever been or are you now in the military? Yes / No

What do you do in your spare time? Hobbies, interests, etc.

Prior Life Experience

Which of the following have you experienced (either currently or in the past)? Please check all that apply.

Physical Abuse	<input type="checkbox"/>	Concerns About Eating/Food	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Death of a Close Family Member	<input type="checkbox"/>	Parents Separation/Divorce	<input type="checkbox"/>	Difficulty in Intimate Relationships	<input type="checkbox"/>
Drug or Alcohol Abuse	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	Physical Health Concerns	<input type="checkbox"/>
Sexual Assault/Abuse	<input type="checkbox"/>	Attempted Suicide	<input type="checkbox"/>	Other Significant Concerns	<input type="checkbox"/>

Which of the above continue to be a problem for you?

Do you have current concerns about alcohol use? Yes / No

Do you have concerns about illegal drug use? Yes / No

Do you overuse prescription medication? Yes / No

Do you have concerns with gambling? Yes / No

Do you have concerns with Internet porn use? Yes / No

Do you have current thoughts of suicide or plans for suicide? Yes / No

Intensity of those thoughts? / 10
(use scale of 1 to 10 where 10 is highest)

Intent to carry them out: / 10

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Have you ever attempted suicide? Y N If so, how many times,
method and at what age(s)?

Are you currently taking any medication? Yes / No
If yes, please list them below.

Name	Dose	Purpose

Previous Therapy Experience

Have you seen a therapist in the past? Yes / No

Date: _____ Purpose: _____

Was it helpful?
Why? _____

Goals for Therapy

What are your main concerns/issues?

How long have you been concerned about this? _____

What are your goals for therapy?

What concerns, if any, do you have about being in therapy?

Signed (Client) _____ Date _____