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Registered Psychologist

The information you provide on this form will not be disclosed to anyone, including those who may attend counselling with you, and will be kept as part of your confidential file. It is not required that you answer all questions; however, your thorough completion of the questionnaire is strongly encouraged, as your responses will enable me to make a more thorough, focused assessment and support more efficient treatment planning and work toward your goals.

Today's Date _____ Name: _____

Age: _____ Date of Birth: _____

Address: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May I leave messages for you at the above phone numbers? _____

May I send mail to the above address? _____

Employer: _____ How long? _____

Occupation: _____

Email address: _____ May I email you? _____

Last year of school completed: _____ College/University (# of years attended): _____

Certificate/Degree/Diploma Pursued/Accomplished: _____

Are you currently in school? _____ If so, what level? _____

Do you enjoy your work or school? _____

Current Relationship Status: Single _____ Married _____ Commonlaw _____ Engaged _____

Separated _____ Divorced _____ Widowed _____

Are you content with your current status? Yes _____ No _____ Unsure _____

If in committed relationship, how long? _____ How would you describe your relationship?_____

How long have you known your partner? _____ How long have you lived together? _____

Partner's Name: _____ Partner's age: _____

Special concerns about partner? (e.g., drinking, anger, illness) _____

Number of previous marriages for you? _____ For your partner? _____

If widowed, separated, or divorced, for how long? _____

With whom do you currently live? Alone _____ Spouse _____ Children _____
(Check all that apply) Parent(s) _____ Sibling(s) _____ Boyfriend _____
Girlfriend _____ Other (please specify) _____

Children:

Name	Sex	Age (or year of death)	Living with you?	Medical/mental health/behaviour concerns	Describe him/her (2-4 words)

Family of Origin:

(Please list mother, father, siblings, stepfamily/foster family relations.
Please also list any other family member who has had a significant impact on your life – either positive or negative).

Name	Relationship to you (mom, sister, etc.)	Current age (or year of death)	Occupation	Medical/mental health concerns	Describe him/her (2-4 words)

Physical History:

Name of Physician:_____ Phone: _____

Address of Physician: _____

Is your physician aware of the concerns that bring you to counselling? Yes _____ No _____

Did he/she recommend counselling for you or your partner? Yes _____ No _____

Are you currently receiving any medical treatment? Yes _____ No _____ If yes, please explain:

_____

Please list any conditions, illnesses, treatments, or surgeries (including pregnancies or related treatments) that might be relevant to your reason for seeking counselling:

_____

Please list all current medications you are taking, and the reason (even if seldomly used or taken only as needed):

Medication	**Which improves/controls:**	**Taken since:**

Is faith/spirituality/meditation a part of your life? _____ If so, in what way? _____

Do you use nicotine or nicotine products? _____ What and how much? _____

Do you drink caffeine/cola/energy drinks? _____ How much? _____

Do you exercise? _____ In what way ? _____ How often? _____

What do you do for fun? _____

Please check any of the following physiological symptoms/sensations that apply to you currently, or in the recent past:

___Headaches ____Rapid Heart Rate ____ Dizziness ___ Visual Trouble ____ Weakness

___ Stomach trouble ____ Difficulty breathing ____ Hearing noises/voices ____ Trouble relaxing

___ Insomnia ___Waking early ___ Trouble falling asleep ___ Tiredness/ No Energy

___ Sleeping too much ___ Change in appetite ___ Pain(specify _____) ___ Other _____

Has your weight changed in the last 2-3 months? _____ Increased? _____ Decreased? _____

Current Status:

Please check all of the following symptoms that apply to you currently:

___ Stress ___Nervousness ____Anxiety ___Panic ___ Cultural concerns

___Worry ___Fears ____Guilt ___Avoiding certain places or people

___Unhappiness/sadness ____Moody ___Apathy/don't care ___Lack of direction

___Trouble concentrating ___Trouble making decisions ____Hopelessness ___Lack of motivation

___Terminal illness ___Recent death in family ____Grief ___Tearfulness

___Inferiority Feelings ___Defectiveness feelings ____Loneliness ___Self-consciousness

___Shyness ___No friends ___Low self-worth ___Identity issues

___Relationship distress ___Communication breakdown ___Arguments ___End of relationship

___Emotional distance ___Lack of affection/caring ____Feeling betrayed ____Lying

___Physical abuse ___Emotional abuse ____Verbal abuse ____Sexual abuse

___Infertility ___Abortion ____Miscarriage ____Pregnancy

___Temper ___Frustration ____Aggressive behaviour ____Anger

___Irritability ____Racing thoughts ___Unwanted thoughts ___Concerns with memory

___Loss of control ____Impulsive behaviour ___Self-control ___Compulsivity

___Sexual intimacy ____Pornography use ____Affair(s) ___Bad dreams

___Cynicism ____ Friendships ____Body image ___Perfectionism

___Illegal drug use ____Alcohol use ____Gambling ___Video gaming ___Shopaholism

___Prescription drug abuse___Compulsive sexuality/deviancy ___Trauma/disaster ___Trauma/victim of crime

___Trouble with job ___Career concerns ___Co-worker conflict ___Chronic lateness or absenteeism

___Educational concern ___Concerns for Child ___Parenting Issues ___Blended family

___Parent-Adult Child ___ Family of origin issues ___Aging parents ___In-law difficulty

___Finances ___Legal Matters ____Spiritual Concerns ____Pre-marital counselling

___ Eating problems* ___Power struggles (with whom?) _____ Other _____

*(___Restricting/Dieting; ___ Binging; ___ Purging Since What age ____ Last Episode _____)

Please indicate on the scale below how distressing your problem(s) are to you. Place an "X" on the line.

_____

Distressed Very Little **Moderately Distressed** **Extremely Distressed**

Extended Family History:

Condition	**Who? (relationship)**	**Approx. When**	**Hospitalization?**	**# of times**
Depression	_____	_____	_____	_____
Bipolar disorder	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____
Other psychotic disorder	_____	_____	_____	_____
Physical/sexual abuse	_____	_____	_____	_____
Substance abuse (alc/drug)	_____	_____	_____	_____
Eating disorder	_____	_____	_____	_____
Chronic/terminal illness	_____	_____	_____	_____
Accidental/untimely death	_____	_____	_____	_____
Unknown mental illness	_____	_____	_____	_____
Domestic violence	_____	_____	_____	_____
Other	_____	_____	_____	_____

Please describe your current use of alcohol/street drugs/non-prescribed prescription drug use below:

Type of alcohol or drug *List each in own box, ie… Beer; Vodka; Marijuana; Tylenol 3*	**Frequency of use** *Indicate how often , Ie… Mj - 3X per day; Beer - 1X per week; Wine - 2X per month*	**How much per day or week?** *List how much , Ie… 3 gm mj daily; 5 beer week; 2 Tylenol 3 daily*	**Age of first use and circumstance?** *Ie… 13 yr old w/uncle at hockey game)*	**Has use increased recently?** *Indicate **from** what amount **to** what amount ie… From: 1 beer/week 3 mo. ago To: 6 beer daily now*
	____X per day ____X per week ____X per month	_____ daily _____ week	____ yr old, with _____ at _____	From: To:
	____X per day ____X per week ____X per month	_____ daily _____ week	____ yr old, with _____ at _____	From: To:
	____X per day ____X per week ____X per month	_____ daily _____ week	____ yr old, with _____ at _____	From: To:
	____X per day ____X per week ____X per month	_____ daily _____ week	_____ yr old, with _____ at _____	From: To:

Is one or more of the above substances a problem for you?At what age & how did it become a problem?

_____

Are you currently experiencing any suicidal thoughts? Yes _____ No _____
Over the past several years, have you frequently experienced suicidal thoughts? Yes _____ No _____
Have you attempted suicide in the past? Yes ___ No ___ When? _____ How? _____
Have any of your friends/family ever committed/attempted suicide? Yes _____ No _____

Who knows you are beginning counselling today? _____
What would you identify as your personal strengths? (ie, sense of humour, flexibility, caring, faith, etc.)
_____

Presenting Issues and Goals:
Please describe briefly why you are coming for counselling (ie, your issues, concerns, problems)
_____
_____

What do you hope to gain or change by coming for counselling?
_____
_____

What is the **first thing** you would notice that would tell you counselling is helping?
_____

How will you know counselling is done? What will be different?
_____

How long do you believe counselling should last? _____

Have you had any previous counselling, psychiatric treatment, or residential/in-patient care? Yes__No__

Month/Year	Duration	Reason	Therapist	Location	Was it helpful?

If you have had previous counselling, what was most helpful?
_____
What was least helpful? _____

Is there anything I may not have asked that you feel it is important or helpful for me to know?
_____

Referral Information:
Please indicate how you learned about my counselling practice. (Check all that apply).
___ Word of mouth (family/friend) _Name_____
___ Another professional (physician, lawyer, psychologist, etc.) Name _____
___ I am a returning client ___ Workshop, seminar, retreat ____ Pastor/Minister/Priest
___ Internet Search led me to www.lynne-goertzen-counselling.com
___ Link from another website ___ Other Source -- Where_____