Julia Kristina Counselling

COUNSELLING CLIENT INFORMATION FORM

Name: _____ Date: _____

Date of birth: _____ Email address: _____

Telephone: _____ Okay to leave a detailed message? Yes / No

Address: _____

Emergency contact person: _____ Relationship to you: _____ Telephone: _____

Family Doctor Name: _____ Telephone: _____

Who referred you or how did you find me? _____

Any current health concerns? Or diagnosis? _____

Current medications and dosage (if applicable): _____

In an average week how many times do you use illicit or recreational drugs (if applicable)? _____

In an average week how many alcoholic drinks do you have (if applicable)? _____

Relationship status: _____ Partner's name: _____

Dependents names and ages (if applicable): _____

Have you ever attended counseling in the past? Yes / No

If so, what did you find the most helpful? _____

What did you find least helpful? _____

Any additional information you think would be useful before we start: _____

Julia Kristina Mah, MA, RCC | #835– 470 Granville Street | Phone: 604-771-3420 | julia@juliakristina.com | www.juliakristina.com