Stephen Giles M.S.W., RSW.

Psychotherapy Practice

NOTE: To avoid a cancelation fee, equal to your booking we require 72hrs notice.

Client Personal Information

Name: _____

Address: _____PostalCode:_____City:_____

Home Phone:_____ Cell:_____ Work:_____

DOB:_____AGE:_____ _

Occupation: _____ Employer_____

Education:_____

Email: _____

Which way is the best way to contact you? _____

Where can I leave a confidential message for you:_____

Single: Yes:___ No_____

Married Yes:___ No_____ How long?_____

Common law Yes:___ No_____ How long?_____

Children: Yes_____ No___ Ages/Sex :_____; _____; _____; _____;

Religion/Spirituality_____ __

Ethnicity/CulturaBackground_____

How did hear about my services?

- ☐ **Doctor/Healthcare Professional (name:)_____**
- ☐ **Friend**
- ☐ **Family**
- ☐ **Google Web Search**
- ☐ **Bing Web Search**
- ☐ **Yahoo Web Search**
- ☐ **Other:_____**

Family Doctor Name: _____Phone: _____

Address:_____

Other Health Care Professionals you see:_____

Emergency Contact

Name: _____ Relation: _____ Phone:_____

Are taking medications: □Yes □ No **If yes please list**

Name	**Dose**	**reason**
1.		
2.		
3.		
4.		
5.		

Have you been in therapy before? □Yes □ No

If yes when was it and what was the outcome? □helpful □ Not helpful

_____

_____

_____

Self Report Mental Health Assessment:

1. Are you concerned about or have experienced any of the below: Please check appropriate box or circle answer:

Sexual Abuse: □Yes □ No □ Maybe □ Past □ Present

Physical Abuse: □Yes □ No □ Maybe □ Past □ Present

Emotional Abuse: □Yes □ No □ Maybe □ Past □ Present

Victim of crime □Yes □ No □ Maybe □ Past □ Present

Other Abuse: □Yes □ No □ Maybe □ Past □ Present

Traumatic Accident Victim (Car accident/disaster/War) □Yes No □ Maybe □

_____

_____

Do you have any Legal Concerns: □Yes No □ Maybe □

_____

_____

Addictive/Risky Behavior (Alcohol/Nicotine/Cocaine/Canabis, Rx drugs/other drugs, Gambling, Pornography/Prostitution)
□Yes □ No □ Maybe □ Please specify:_____

Addiction Issues	□Yes	□ No	□ Maybe
Depression:	□Yes	□ No	□ Maybe
Anxiety:	□Yes	□ No	□ Maybe
Anger	□Yes	□ No	□ Maybe
Low self-esteem:	□Yes	□ No	□ Maybe
Mental Health:	□Yes	□ No	□ Maybe
Affairs/Betrayal	□Yes	□ No	□ Maybe
Have you considered suicide:	□Yes	□ No	□ Maybe

Do you or your spouse have addiction issues? □Yes □ No □ Maybe

Have you ever had suicidal thoughts or feelings? □Yes □ No □ Maybe

Has a Family member attempted or completed suicide? □Yes □ No Maybe□

Are you experiencing stress with:

Work	□Yes	□ No	□ Maybe
Family:	□Yes	□ No	□ Maybe
Parenting:	□Yes	□ No	□ Maybe
Friends:	□Yes	□ No	□ Maybe
Spouse/Sig Other	□Yes	□ No	□ Maybe
Snoring:	□Yes	□ No	□ Maybe
Sleep :	□Yes	□ No	□ Maybe

Has there been any major changes/stressors in your life over the last year(s)?
□Yes □ No □ Maybe

If yes or maybe – please explain:_____
_____
_____
_____
_____

History of Medical issues? □Yes □ No □ Maybe **please list.**
_____
_____
_____
_____
_____

What is your Employment/Unemployment History: Last 5 years -

_____
_____
_____
_____
_____

What is your Romantic Relationship History: Last 5 years

_____
_____
_____
_____
_____

Do you have any concerns not mentioned above? If yes please explain

_____

What personal strengths do you bring to therapy: (examples: personality and character traits; family and friends support; past accomplishments etc)

_____
_____
_____

What have you tried that has helped with your current situation?

_____
_____
_____

Why are you here? Do you have goals? What Can I help you with?

_____
_____
_____
_____
_____
_____

_____ _____ _____

Your Signature **Your Printed Name** **Date**