STOP

CLIENT REFERRAL FORM

Name:____Date: _____________________________

Please fill in the sections that apply to you. All information is kept strictly confidential.

Confidentiality Agreement - *Please carefully review the following information.*
Confidentiality is an important aspect of your counselling, so please feel free to ask any questions at any time. Counselors have a primary obligation to respect the confidentiality of information obtained from persons in the course of their work as counselors. They reveal such information to others only with the consent of the person or person's legal representative, or in unusual circumstances in which not to do so would result in clear danger to the person or to others. Where appropriate, counselors inform their clients of the legal limits of confidentiality, which are: The therapist may be required to give evidence if subpoenaed by a court of law; The therapist may report concern to appropriate persons if there is reason to believe that as a result of a client's actions the life or well-being of any person might be endangered; The therapist will inform the appropriate authorities if there is suspicion that a client is responsible for a child being abandoned, deserted or maltreated.

Do you have access and/or the ability to participate through a virtual or online platform? YES ☐ NO ☐

Birth Date:_________________________________Age:____________Gender: _____________________

Marital Status: (Please circle)

Never Married Domestic Partnership Married Separated Divorced Widowed

Please list any children/age: ____

Address: ____
(Street and Number)

____
(City) (Province) (Postal Code)

Home Phone: ( ) May we leave a message? Yes ☐ No ☐
Cell/Other Phone: ( ) May we leave a message? Yes ☐ No ☐

Email:____May we email you? Yes ☐ No ☐

* Please note: Email correspondence is not considered to be a confidential medium of communication.

Have you previously received any type of mental health services (therapy, counseling, psychiatric services, etc.)? Yes ☐ No ☐

Are you currently taking any prescription medication? Yes ☐ No ☐
Please list: ____________________
Have you ever been prescribed psychiatric medication? Yes ☐ No ☐
Please list and provide dates if known: ____________________

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

____
____
____
____

2. How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

____
____

3. How many times per week do you generally exercise? ____________________
What types of exercise do you participate in? ____________________
____
____

4. Please list any difficulties you experience with your appetite or eating patterns

____
____

5. Are you currently experiencing overwhelming sadness, grief or depression? Yes ☐ No ☐
If yes, for approximately how long? ____________________

6. Are you currently experiencing anxiety, panic attacks or have any phobias? Yes ☐ No ☐
If yes, when did you begin experiencing this? ____________________
____

7. Are you currently experiencing any chronic pain? Yes ☐ No ☐
If yes, please describe ____________________
____

8. Do you drink alcohol more than once a week? Yes ☐ No ☐

9. How often do you engage in recreational drug use? (Circle One)
   Daily Weekly Monthly Infrequently Never

10. Are you a smoker? Yes ☐ No ☐

11. Are you currently in a romantic relationship? Yes ☐ No ☐
    If yes, how long? ____

    On a scale of 1-10 (1: Poor & 10: Great) how would you rate your relationship? ____

12. What significant life changes or stressful events have you experiences recently:
    ____
    ____
    ____
    ____
    ____
    ____
    ____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (Father, grandmother, uncle, etc.).

Alcohol/Substance Abuse

____

Anxiety

____

Depression

____

Domestic Violence

____

Eating Disorders

____

Obesity

____

Obsessive Compulsive Behaviour

____

Schizophrenia

____

Suicide Attempts/Thoughts

____

ADDITIONAL INFORMATION:

1. Are you currently employed? Yes ☐ No ☐
If yes, what is your current employment situation?

____

Do you enjoy your work? Is there anything stressful about your current work?

____
____

2. Do you consider yourself to be spiritual or religious? Yes ☐ No ☐
If yes, describe your faith or belief:

____

3. What do you consider to be some of your strengths?

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____
____
____

4. What do you consider to be some of your weaknesses?

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5. What would you like to accomplish out of your time in session?

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NOTES:

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