CLIENT INFORMATION QUESTIONNAIRE

Your completion of this comprehensive questionnaire is helpful in understanding you and planning my services with you. Please answer each item carefully and feel free to use the back pages to add any other information that you feel would be important for me to know.

Ensure that you have all the pages, including Confidentiality and Consent form as well as the office policy for cancellations. Thank you.

Today's Date ______________________________

Name: ______________________________________Partner: ________________________________

Address: ____

City/ Province: _____________________________Postal Code: _____________________________

Phone: H: ______________________B: ____________________________C: ______________________

Email: ____

Age: _________Birthdate: ____________________Marital Status: __________________________

Occupation: _________________________________Employer: ______________________________

Highest Level of Education Completed: ____

Who referred you here? ____

Physician's Name: ___________________________Phone: __________________________________

When did you last see physician? ____

Complementary Practitioners: ____

Significant Family History: ____

List health issues for which you are currently receiving treatment or have challenges with: ____

____

____

Have you experienced trauma? ____

Do you consider yourself to be a spiritual person or follow a particular faith? _______

____

List major surgeries: ____

____

List medications and dose: ____

____

List nutritional supplements: ____

____

Healthy Lifestyle: Good __________ Fair_______________Poor____________________________

Do you smoke? ________ How much? __________
Do you drink? __________How much? __________
Do you use recreational drugs? _______What?________________How often?____________
Do you have other addictive behaviors? ___________What:?____________________________

Have you received psychiatric or psychological help before? ________________________

For what? ____

When? ____

What complementary healing modalities have you tried? ____________________________

____

What are your goals and expectations for this appointment__________________________

____

____

*Please use the back of these forms for additional information

Please circle any of the following problems as they pertain to you:

Stress	Relaxation	Negative Thoughts
Communication	Conflict	Infidelity
Loneliness	Friendships	Unhappiness
Separation	In-Laws	Relatives
Work	Career Choices	Finances
Depression	Suicidal Thoughts	Fears/Anxiety
Parenting	Children	Education
Appetite	Exercise	Weight Issues
Sexual Abuse	Intimacy	Safety/Trust
Physical Abuse	Anger	Self-Control
Emotional Abuse	Self-Esteem	Confidence
Headaches	Stomach/Bowel	Chronic Pain
Insomnia	Nightmares	Tired/Fatigued
Addictive Behavior	Alcohol/Drugs	Eating Disorders
Guilt	Forgiveness	Punishment

What are the main reasons you are seeking help today:

____

____

Please read and sign to indicate agreement to and understanding of the following:

Payment is due after each session. Any cancellations will be accepted 48 hours prior to your scheduled appointment time. You will be responsible for payment of a full session fee for late cancellations or missed appointments.

Read and Signed: ____

STATEMENT OF CONFIDENTIALITY AND CLIENT CONSENT

CONFIDENTIALITY

Your therapy is protected by strict ethical guidelines. Your psychologist will not share information without your written permission, except as required by law. If you are a minor, there may be instances where your parents would have the right to know about some things because they are your legal guardians. However, your psychologist would usually make an agreement with your parents before therapy begins.

Federal and Provincial regulations require disclosure of information related to:

- Suspected child abuse or neglect
- Threats or intention to physically harm oneself or another person
- Acts of physical or sexual abuse

In these instances, your psychologist is legally and ethically obligated to report these acts to the appropriate authority to keep you or someone else safe.

In this era of technology, I acknowledge that email transmission is not secure and therefore not appropriate for discussion or transmission of content that is therapeutic in nature. Additionally, consultations that are done via Skype or Face-Time rely on the client ensuring privacy that is not within the control of the therapist.

I have read this statement and acknowledge its' conditions.

____ Date: ______________
Signature of Client

CLIENT CONSENT

To provide continuity of care, I give my psychologist, Deborah R. Lain, MSc., permission to speak with or write a letter to the referring specialist/physician/holistic practitioner, __________________________________indicating my goals for therapy, assessment and recommendations. Requests for any other psychological reports for medical, legal or insurance purposes will be discussed and fees agreed upon prior to submission of the report.

____ Date: _____________
Signature of Client

____
Deborah R. Lain, MSc. Registered Psychologist