



PERSONAL INFORMATION (Please Print)

Name _____ Today's Date _____

Preferred Pronouns _____ Address _____

City _____ Province _____ Postal Code _____

Birthdate (d/m/y) _____ Cell Phone _____ Home Phone _____

E-mail _____ Occupation _____

Emergency Contact (name & number) _____

STATUS	HOW LONG	STATUS	HOW LONG
Single		Partnered	
Dating		Separated	
Engaged		Divorced	
Married		Widowed	

Current Partner's Name _____ Birthdate (d/m/y) _____

Children's Name(s)	Age	Children's Name(s)	Age

REFERRAL INFORMATION

How did you hear about MCG Counselling?

Internet Friend/Acquaintance Doctor Other

PREVIOUS COUNSELLING

Have you attended counselling before?

If "YES", please list as follows:

COUNSELLOR	ORGANIZATION	CITY	WHEN

PRESENT COUNSELLING DETAILS

Medical conditions: _____

Medications: _____

Primary Physician: _____

What is important for me to know about your spiritual or religious background and your current practices and beliefs? _____

What is important for me to know about your ethnic or cultural background and current practices? _____

Do you feel safe in your current relationships? _____

Issues with sleep or appetite: _____

Issues with memory or concentration: _____

Issues with sexuality, gender identity or sexual orientation: _____

Do you live with depression or anxiety? _____

Do you have thoughts or plans of self harm? _____

Do you have thoughts of suicide? _____

Substance use: What Substances? _____ How often? _____

Has your substance use ever caused problems for you or others? _____

Would you describe your work environment as more supportive or more problematic?

Would you describe your home environment as more supportive or more problematic?

What concerns are you wanting to discuss today?
