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New Client Questionnaire

The information provided below will help me to understand your personal background including some of the personal issues that you have faced in your lifetime, and whether these continue to impact your current quality of life. You may recognize that some of these topics/issues will apply to you while others do not and this is normal. Feel free to add to the information by writing on the back of the form as well.

DEMOGRAPHIC INFORMATION

Name: ______________________________ **Date of Birth:** _________________________

Address: _____________________________ **Phone Number**: (H) __________________
_____________________________________ (C) __________________
_____________________________________ (W) __________________

E-mail_______________________________

Emergency Contact: _______________ **Relation to me:**_________ **Phone Number:** ________

Preferred way of receiving appointment reminders/confirmations: ☐ Text ☐ Email

How did you find me?

☐ Friend ☐ Family ☐ Google ☐ Psychology Today ☐ Other _____________

What is your current gender identity: ☐ Female ☐ Male ☐ Prefer not to respond

Family Physician: _____________ **Physician Contact Number**: _____________

Weight: _____________ lbs. **Height:** _____________ ft./inches

Present Occupation: _____________ ☐ **Student (Grade/Year**: _____________)

Are you satisfied with your current occupation? ☐ Yes ☐ No

☐ **Unemployed**

If you are currently unemployed, for how long have you been out of work? _____________

Reason for unemployment:____

Highest Level of Education Achieved: _____________

Marital Status: ☐ Single ☐ Living Together ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If married or living together, for how long? _____________

If separated/divorced, since what year? _____________

How would you describe the process of your separation/divorce?

____

____

Do you believe your significant relationship/marriage and/or divorce is an area that negatively impacts your quality of life: ☐ Yes ☐ No

If your partner is deceased, what year did he/she/they pass? _____________

What was the cause of his/her/their death?

____

____

____

Do you have Children/Step Children? ☐ Yes ☐ No

If so, how many? _____________

Children/Step children:

1. Name: _____________ Age: _________ Sex: ______ Currently Resides: _________
2. Name: _____________ Age: _________ Sex: ______ Currently Resides: _________
3. Name: _____________ Age: _________ Sex: ______ Currently Resides: _________
4. Name: _____________ Age: _________ Sex: ______ Currently Resides: _________
5. Name: _____________ Age: _________ Sex: ______ Currently Resides: _________

Do you believe your relationship with your children/step-children is an area that negatively impacts your quality of life: ☐ Yes ☐ No

Are you caring for any other dependants (e.g. parents, grandparents, foster children etc…)?

____

____

____

GENERAL HEALTH

Are you taking any medications at present? If so, please list?

1. Medication: ___________ Prescribed by: ____________ Date started (approx.): _________
2. Medication: ___________ Prescribed by: ____________ Date started (approx.): _________
3. Medication: ___________ Prescribed by: ____________ Date started (approx.): _________
4. Medication: ___________ Prescribed by: ____________ Date started taking: _________

Do you have any current health problems or concerns?

____

____

____

Have you have had appointments with any of the following health care providers over the past three months? (If so, please indicate the number of visits in the past 3 months)

- ☐ Family Doctor — Visits: _____
- ☐ Walk- In Clinic — Visits: _____
- ☐ Specialist (i.e. Ob-gyn, Cardiologist, etc.) — Visits: _____
- ☐ Psychiatrist — Visits: _____
- ☐ Therapist — Visits: _____
- ☐ Family Therapist/Family Counsellor — Visits: _____
- ☐ Dietician — Visits: _____
- ☐ School or Guidance Counsellor — Visits: _____
- ☐ Nurse (visiting nurse, public health, etc.) — Visits: _____
- ☐ Emergency Room — Visits: _____
- ☐ Distress Phone Line — Visits: _____
- ☐ Hospital - Visits in past 3 months — Visits: _____
- ☐ Other: ______________ — Visits: _____

What was the main reason for accessing this care?

____

____

____

Current medical issues I am facing include the following:

- ☐ Cardiac
- ☐ Gastrointestinal
- ☐ Neurological
- ☐ Muscular/Skeletal/Orthopedic
- ☐ Respiratory
- ☐ Obstetrical/Gynecological
- ☐ Allergy/Immunological
- ☐ Other: ______________

My medical/physical health is an area that impacts negatively on my quality of life? ☐ Yes ☐ No

Chronic pain is something that I deal with on a daily basis? ☐ Yes ☐ No

If yes, what are the primary areas of concern/diagnoses?

____

____

Who is following your care?

____

____

What methods are you currently using for pain management?

____

____

On average how many hours of sleep do you get per night? ________

Do you typically wake feeling rested? ☐ Yes ☐ No

Do you currently take medication or supplements to help you with your sleep? If yes, please list:

____

____

Are you happy with the weight you are at right now? ☐ Yes ☐ No

If not, do you feel you need to gain or lose weight? ☐ Gain ☐ Lose

Have you tried to control your weight in the past? ☐ Yes ☐ No

If yes, which of these measures have you taken to control your weight?

☐ Diet
☐ Join a diet program (ex. Weight Watchers)
☐ Increased Activity
☐ Diet Pills
☐ Food Restriction
☐ Laxatives
☐ Vomiting
☐ Excessive Exercise
☐ Weight Loss Medicines (i.e. Wegovy, Ozempic, etc…)
☐ Surgery (i.e. Bariatric Surgery, Liposuction, etc…)

My eating habits, body weight, and/or shape are areas that impact negatively on my quality of life?

☐ Yes ☐ No

ACTIVITY LEVELS

How many hours per week are you active? This includes activities such as walking, gardening, sports of all types, and trips to the gym.

☐ 0-2 hours ☐ 3-5 hours ☐ 6-8 hours ☐ 9-12 hours ☐ 13+ hours

I believe this is:

☐ The right activity level for me
☐ Not enough activity for me
☐ Too much activity for me

My reasons for exercising include:

☐ Socializing
☐ Feel good about myself
☐ Compensate for food and eating
☐ Cope with stress
☐ Help with effects of aging
☐ Involved in an organized sport recreationally (Which sport(s) ______________)
☐ Involved in an organized sport at an elite level (Which sport(s) ______________)

Activities I enjoy include:

____

____

My activity level is an area that negatively impacts my quality of life? ☐ Yes ☐ No

SEXUALITY

* If at all uncomfortable you are welcome to leave this section blank.

Please respond yes or no to the following:

I am comfortable with the level of intimacy in my current relationship? ☐ Yes ☐ No

I am comfortable with who I am sexually? ☐ Yes ☐ No

Sexual intimacy is an area that impacts negatively on my quality of life? ☐ Yes ☐ No

MENTAL HEALTH TREATMENT HISTORY

Have you previously received treatment for issues related to your mental health? ☐ Yes ☐ No

Please indicate the type the duration and location for each service that applies:

☐ Individual therapy Duration: ______________ Location: ______________
☐ Group therapy Duration: ______________ Location: ______________
☐ Family Therapy Duration: ______________ Location: ______________
☐ Other: ______________ Duration: ______________ Location: ______________

I attended these treatments for help with issues related to:

☐ Anxiety
☐ Depression
☐ Trauma
☐ Sexual Abuse
☐ Separation and Divorce
☐ Learning Disability
☐ Substance Abuse
☐ Gambling
☐ Body Image and Weight
☐ Eating Disorder
☐ Motor Vehicle Accident
☐ Medical Illness
☐ Parenting
☐ Grief/Loss
☐ Autism or other Developmental disorders
☐ Other: ______________

SUBSTANCE ABUSE HISTORY

Alcohol use:
Do you believe that you currently have an alcohol problem? ☐ Yes ☐ Possibly ☐ No
Do you believe that you have ever had an alcohol problem? ☐ Yes ☐ Possibly ☐ No
Has anyone ever complained about your use of alcohol? ☐ Yes ☐ Possibly ☐ No

Drug Use:
Do you currently use drugs? ☐ Yes ☐ No
Have you ever used drugs? ☐ Yes ☐ No
Do you believe you have or have ever had a drug use problem? ☐ Yes ☐ Possibly ☐ No
Has anyone ever complained about your drug use? ☐ Yes ☐ Possibly ☐ No

SELF HARM HISTORY

Have you every attempted suicide (tried to kill yourself)? ☐ Yes ☐ No

If so, how many times? _____________

Have you ever tried to physically harm yourself (i.e. cut, burn, hit self, etc.) ☐ Yes ☐ No

If so, how many times? _____________

ABUSE HISTORY

Do you believe you have been physically abused (hit, beaten, burned, etc.)?

☐ Yes ☐ Possibly ☐ No ☐ Unsure

Do you believe you have been sexually abused (unwanted sexual contact)?

☐ Yes ☐ Possibly ☐ No ☐ Unsure

Do you believe you have ever been emotionally abused (called names, put down, etc.)?

☐ Yes ☐ Possibly ☐ No ☐ Unsure

Do you believe you have been emotionally neglected (emotional needs not treated as important)?

☐ Yes ☐ Possibly ☐ No ☐ Unsure

PERSONAL RESIDENCES

How many locations and houses did you reside prior to age 18? _____________

How many locations and houses have you resided in after the age of 18? _____________

If you have moved many times, what were the reasons for this?

____

____

____

____

ACADEMIC HISTORY

☐ Not currently a student ☐ Full-time student ☐ Part-time student

Highest level of education completed to date:

Grade: ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13

OR: ☐ some college ☐ college graduate ☐ some university
☐ Bachelor’s ☐ Master’s ☐ Doctorate
☐ Other: _____________

Have you ever been diagnosed with any learning disabilities or been identified as neurodiverse such that this would have impacted directly on your learning, work performance or day to day life activities? (i.e. Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), Autism, Asperger's, etc…)

☐ Yes ☐ No

If yes, please indicate which one(s) you suspect or have been formally diagnosed with:

____

____

My learning disabilities/neurodiversity impacts negatively on my quality of life? ☐ Yes ☐ No

Do you speak/understand any other languages besides English? ☐ Yes ☐ No

If yes, please indicate which ones:

____

____

FAMILY AND RELATIONSHIPS

How many male siblings do you have? ______

How many female siblings do you have? ______

How many non-binary siblings do you have? ______

Is your mother, either biological or adoptive, still alive? ☐ Yes ☐ No

Is your father, either biological or adoptive, still alive? ☐ Yes ☐ No

How many close friends do you have?

☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 5+

How many people (including family) could you talk to about an important personal problem?

☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 5+

How many hours a week do you socialize with friends outside of work/school hours?

☐ Under 1 hour ☐ 1-2 hours ☐ 3-4 hours ☐ 5-6 hours ☐ 7-8 hours ☐ 9+ hours

Please check the box that best represents the quality of your relationship with each of the following people:

1. **Mother** ☐ Does not apply ☐ Poor ☐ Fair ☐ Good ☐ Excellent
2. **Father** ☐ Does not apply ☐ Poor ☐ Fair ☐ Good ☐ Excellent
3. **Spouse/boyfriend/girlfriend** ☐ Does not apply ☐ Poor ☐ Fair ☐ Good ☐ Excellent
4. **Female siblings** ☐ Does not apply ☐ Poor ☐ Fair ☐ Good ☐ Excellent
5. **Male siblings** ☐ Does not apply ☐ Poor ☐ Fair ☐ Good ☐ Excellent
6. **Non-Binary siblings** ☐ Does not apply ☐ Poor ☐ Fair ☐ Good ☐ Excellent
7. **Male friends** ☐ Does not apply ☐ Poor ☐ Fair ☐ Good ☐ Excellent

8. **Female friends** ☐ Does not apply ☐ Poor ☐ Fair ☐ Good ☐ Excellent
9. **Non-Binary Friends** ☐ Does not apply ☐ Poor ☐ Fair ☐ Good ☐ Excellent
10. **Children** ☐ Does not apply ☐ Poor ☐ Fair ☐ Good ☐ Excellent

The quality of my relationships is an area that negatively impacts my life? ☐ Yes ☐ No

Spiritually, I would describe myself as (check all that apply):

☐ Quite spiritual
☐ Not at all spiritual
☐ Having a faith that I am connected to and practice
☐ Spiritual but not connected to an organized religion
☐ Someone who was raised in a very strict religious home that I continue to practice
☐ Someone who was raised in a very strict religious home that I **no longer** continue to practice
☐ Feel that having a sense of purpose in my life is important

I have engaged in the following activities either on my own or as part of a class:

☐ Yoga ☐ Meditation ☐ Relaxation Training
☐ Faith Retreats ☐ Faith Based couples retreats

My spirituality is an area that impacts negatively on my quality of life? ☐ Yes ☐ No

FINANCES

I know what I need to do when it comes to managing my personal finances? ☐ Yes ☐ No

I am typically pretty good at following through and doing what I need to do when it comes to managing my personal finances? ☐ Yes ☐ No

Does your current financial status negatively impact the quality of your life? ☐ Yes ☐ No

FINAL THOUGHTS

What concerns have brought you in for therapy/counselling at this time?

____

____

____

How will you know that coming for therapy/counselling had been worth your while?

____

____

____

Is there anything else that you feel I ought to know about you in order to be helpful?

____

____

____

Thanks for taking the time to complete this questionnaire!

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