Confidential Client Information

Welcome to Bloom Counselling & Consulting. We want to make the most of each appointment you have with us. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely and legibly as possible. This information is confidential. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.

First Name: ____________________________ Last Name: ____________________________

Pronouns: She/Her/Hers He/Him/His They/Them/Theirs

Address: ____

City: _________________________ Province: _________ Postal Code: _______________

Cell Phone: ______________________________ Can we leave a message? ☐ Yes ☐ No

Work/Home Phone: _______________________ Can we leave a message? ☐ Yes ☐ No

Email: _____________________________________ Contact via email OK? ☐ Yes ☐ No

Age: ________ Birthdate: _________________ Birthplace: ______________________________

Education : Highest grade _______ Post secondary: ____

Current Occupation: ___________________________ Job satisfaction: -
low high

Person to alert in the event of medical emergency: ____

Relationship to you: _______________________________ Phone: ___________________________

Family Doctor: __________________________________ Phone: ___________________________

Relationship status: ☐ Single ☐Married ☐Partnered ☐ Separated ☐ Divorced ☐Widowed ☐Other

Spouse/partner's 1st name: _______________________________ Age: _____ Yrs in relationship: _____

Education: Highest grade ________ Post secondary: ____

Current Occupation: _______________________ Marital satisfaction: -
low high

Other significant close relationships:

Name: ___________________________________ Relationship: ___________________________

Name: ___________________________________ Relationship: ___________________________

Siblings	
M/F	Age

Children/Dependents/Pets		
Name	Birthdate (day/month/year)	Age

Parental Marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Mother alive? ☐ Yes ☐ No If deceased, please note year of death:

Mother's birthplace: ________________________ Mother's profession: ________________________

Your relationship with mom is best described as: ☐ Close ☐ Somewhat close ☐ Distant ☐ Conflicted

Father alive? ☐ Yes ☐ No If deceased, please note year of death:

Father's birthplace: ________________________ Father's profession: ________________________

Your relationship with dad is best described as: ☐ Close ☐ Somewhat close ☐ Distant ☐ Conflicted

Please check all that may apply:

☐ Depressed mood
☐ Racing thoughts
☐ Excessive worry
☐ Inability to enjoy activities
☐ Impulsivity
☐ Anxiety attacks
☐ Sleep disturbances or changes
☐ Increase in risky behavior
☐ Avoidance/withdrawal
☐ Loss of interest
☐ Increased libido
☐ Decreased libido
☐ Appetite changes
☐ Crying spells
☐ Hallucinations
☐ Excessive guilt
☐ Increased irritability/anger
☐ Excessive energy
☐ Fatigue
☐ Concentration/memory
☐ Feeling numb

Please describe any other significant current or past medical problems: ____________________________

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History of abuse? ☐ Verbal/emotional ☐ Physical ☐ Sexual ☐ Other

Alcohol use: ☐ Never ☐ Occasional ☐ Frequent ☐ Dependent

Non-medicinal drug use: ☐ Never ☐ Occasional ☐ Frequent ☐ Dependent

Have you had thoughts of self harm or suicide? ☐ Yes ☐ No ☐ Presently experiencing

Have you previously developed a plan for suicide, or have a history of attempts? ☐ Yes ☐ No

Please list any medications you currently take. Please include prescription and over the counter meds.

Medication	Date	Reason

Have you had previous psychological care or counseling? ☐ Yes ☐ No

If yes, please give the name of the clinician(s), the months you saw them (e.g., Nov 06 - Feb 07), and the nature of the difficulty at the time.

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Have you ever been hospitalized for a psychological difficulty? ☐ Yes ☐ No

If yes, please give the dates and the nature of the difficulty at the time: ____________________________

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Have there been any recent life changes or stressors you have experienced? __________________________

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Please briefly describe previous experiences with grief and loss: ________________________________

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In your own words, what is the nature of the concern that you wish to address in therapy? Feel free to describe this in as much or as little detail as you wish.

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Therapy can be a powerful force for change. In order for it to be most effective it helps to have a clear and specific goal. You may find it difficult to express your hopes for therapy in the form of a goal, but please make at least an initial effort. You can discuss this further with your therapist. Feel free to list more than one goal if you wish.

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