



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: _____

Preferred Name: _____ Pronouns: _____

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: _____

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: _____

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:

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

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

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, including prescription and over the counter meds.

Medication	Date	Reason

Have you had previous psychological care or counseling? Yes No

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

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.

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.
