OCFI Ottawa Couple & Family Institute

PERSONAL INFORMATION

Date:

☐ **Individual Therapy** ☐ **Couple Therapy** ☐ **Family Therapy**	
Name:	**D.O.B:**
Address:	**Pronouns:**
E-mail:	**Phone:**
Relationship status:	Other: _____
Who referred you to our services?	
Name of primary care provider: **(ex: Family physician, Nurse Practitioner, Naturopath, etc.)**	☐ No primary care provider
Practice name:	**Address:**
Telephone number:	

*The questions on this form are intended to help your therapist get a better understanding of your history prior to meeting. However, answering these questions is **not** mandatory, as we understand that some questions would be better addressed in session with your therapist. Feel free to provide as much or as little information as you wish, or to mark 'no answer' on any question you'd rather address with your therapist.* ***The information on this form will be stored in your file and all information provided will be kept confidential.***

Please briefly describe your main problem or issue for which you are seeking therapy.

How long has this been an issue?

Over time, this issue has: ☐ improved ☐ gotten worse ☐ stayed the same

How has this affected your ability to function at work, home, or school?

Have you experienced this issue before? When?

Have you been in therapy previously? If so, could you please provide the therapist(s) name(s) and approximate length of therapy, as well as any information you believe would be relevant to our work together.

Do you have any goals for therapy? If so, please describe.

Have you ever received a diagnosis from a mental health provider? If so, please elaborate.

Are you currently involved in any litigation or do you have any unsettled legal matters? If so, please elaborate.

Do you have any supports in your life: someone else to talk and share your feelings with?

Do you belong to any clubs/organizations? (e.g., faith community, clubs, sports, etc)

Is there anything you feel is important for us to know about your culture, race, ethnicity, religion, spirituality, sexual orientation, gender identity, language, or other?

Have you ever experienced abuse (e.g., emotional, physical, sexual, financial, etc) or witnessed violence? ☐ Yes ☐ No

Have you or your loved ones ever been concerned about your alcohol/drug use? ☐ Yes ☐ No

Have you ever thought about ending your life? ☐ No ☐ Yes **If so, how often?**

Have you ever attempted to end your life? ☐ No ☐ Yes

If yes, what was the date of the most recent attempt?

MEDICAL INFORMATION

When did you last have a check-up?

Do you currently have a medical condition that requires treatment? ☐ No ☐ Yes (please describe below)

Do you take prescription medication? ☐ No ☐ Yes (please list medication names & dosages):

How frequently do you use alcohol?

How frequently do you use recreational drugs? Which drugs?

Have you ever sought treatment related to substance abuse or other addiction?

Is there anything important about your physical health that we should know?

Is there anything about your family health history that you think we should know?

RELATIONSHIP HISTORY

Are you currently in a relationship? ☐ Yes ☐ No **Length of relationship:**

Do you live with your partner? ☐ Yes ☐ No **Length of cohabitation:**

Do you have children? ☐ No ☐ Yes (if yes, please list their names and ages below)

Is there anything we should know about your current relationship or past relationships?

Please list the members of your household
(Who lives with you?)

Name	Relation (e.g., child, spouse, etc.)	D.O.B.

Is there anything else you would like to share with your therapist prior to the initial appointment? You can add as much or as little information as you would like here.

EMERGENCY CONTACT INFORMATION

Name: **Relation:**

Phone:

Is this person aware you are in counselling? ☐ Yes ☐ No

* Please note that this person could be contacted if there is an imminent risk of you harming yourself or others (e.g., high risk of suicide).