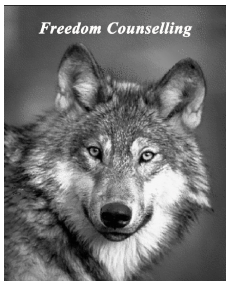
New Client Form

Please download this form to your computer. Once completed, click the submit button and the form will redirect to your email and will then be ready to be sent.

Thank You



VELMA JOHNSON, M.Sc., R.S.W.

Confidential Client Information Form (Adult)

The information requested on this form is important for our records and will be held in strict confidence. Information will not be released without your specific request. This form is the property of Freedom Counselling.

General Information

Date:_____ **How Did You Learn of Our Services?**_____

Name: _____ _____

Last Name **First Name**

□ Male □ Female **Age:**_____ **Date of Birth:**_____ **(Optional)**

Contact Information

Street Address:_____ **Suite or Apt. #:**_____

City:_____ **May We Send Mail Here:** ☐ **Yes** ☐ **No**

Mailing Address or Post Office Box:_____

City:_____ **May We Send Mail Here:** ☐ **Yes** **□ No**

Home Phone: ( )_____ **May We Leave a Message Here:** ☐ **Yes** **□ No**

Mobile Phone: ( )_____ **May We Leave a Message Here:** ☐ **Yes** **□ No**

Work Phone: ( )_____ **May We Leave a Message Here:** ☐ **Yes** **□ No**

Email Address:_____ **May We Send a Message Here:** ☐ **Yes** **□ No**

Employment Information

Employer:_____ **Length of Employment::**_____

Occupation:_____

Average Hours Worked per Week:_____

Employee Assistance Plan:

Are You Covered by an Employee Insurance/benefits Plan? _____Yes _____No

Name of Eap/insurance Co. _____

Relational Information

Current Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed □ Common Law

If Married or Common Law, for How Long:_____

Number of Previous Marriages or Common Law Relationships You:_____ **Partner?**_____

If Separated or Divorced, How Long: _____ If Widowed, How Long:_____

with Whom Do You Currently Live (Check All That Apply): □ Alone □ Spouse □ Children □ Parent(s)

□ Sibling(s) □ Boyfriend □ Girlfriend □ Other:_____

Partner Information

Name: _____ _____

Last Name **First Name**

How Many Hours a Week Do They Work:_____

Children

List Your Children (Living or Deceased)

Name	Sex	Age	Relationship to You (E.g. Natural, Step, Adopted)	Living with You?	How Would You Describe Him/Her

Medical Information

Primary Physician:_____ **Phone: ( )**_____

Are You Currently Receiving Medical Treatment: ☐ **Yes** ☐ **No. If Yes, Please Specify:**_____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas, or Related Treatments You've Had

_____

Has Your Weight Changed in the Last 2-3 Months: _____Yes _____No

List Any Anti-depressant or Anti-anxiety Medication

Medication	Dosage (Mg)	Improves, Prevents or Controls My	How Long Have You Been on this Medication? (Months)

Are You Taking These Medication(s) According to Your Doctor's Recommendations: ☐ **Yes** ☐ **No.**

Please read the following:

Confidentiality:

All records and communications are considered confidential, but I am required by law to report actual or suspected child abuse or possible suicide or homicide. Counselling records may only be released with your written consent or by court order.

Fees:

Fees are payable after each session unless covered by an Employee Assistance Plan.

Cancellations:

If you must cancel an appointment, please call at least 24 hrs. in advance. If advance notice of cancellation is not given, the session may be charged at the usual rate.

I have read the above information and understand this confidential questionaire and release form.

Signature:_____ **Date:**_____

Submit