

FIRST LIGHT COUNSELLING
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Client Information

GENERAL INFORMATION:

Name _____ Date of Birth (Age) _____

Address: _____

Telephone/Cell: _____ Email: _____

Marital Status: _____ Partner's Name: _____ Length in relationship: _____

Children: _____

Emergency contact: _____ Telephone/Cell: _____

FAMILY HISTORY:

Father _____ (age) _____ Current Employment _____

Mother _____ (age) _____ Current Employment _____

Other relationships: _____

Siblings _____

HEALTH HISTORY:

Current or chronic health problems: _____

Medications: _____

Date of last physical: _____ Head injuries/surgeries: _____

Drug/Alcohol use: _____

Previous Therapy: _____ What worked and did not work for you: _____

Any issues of mental health or addiction in your family _____

CURRENT FUNCTIONING:

Current Employment: _____ What kind of work do you do: _____

How long have you work: _____ How do you feel about your work: _____

Any work related difficulties: _____ Relationship to employer/coworkers _____

Tell me about your friends: _____ How often do you see them: _____

What do you enjoy doing for fun: _____

Tell me about your current relationship and degree of satisfaction: _____

Any difficulties in the relationship: _____

DRUG HISTORY

How are your emotions affected by caffeine/tea/coffee/alcohol: _____

How are your emotions affected by your 1st, 2nd or 3rd drink: _____

Other substances (nicotine, marijuana, heroin, etc.) : _____

TREATMENT EXPECTATIONS

Why are you seeking therapy at this time: _____

Expected/hoped for outcome: _____

What can I do for you as your counsellor: _____

How will we know when our work is finished: _____

What goals would you like to have for counselling: _____
