T 807 621 0906
E INFO@MONIQUEGOUTHRO.COM

Introductory Interview (Adult)

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session.

Name:
_____

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____

Local Address: _____
(Street and Number)

_____
(City, Province, Postal Code)

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Other Phone: _____ May we leave a message? □ Yes □ No

E-mail: _____May we email you? □ Yes □ No
*Please be aware that email might not be confidential.

Emergency Contact (name, relationship, phone number):

_____

I, the undersigned, give permission for Monique Gouthro to contact the above person in the event of an emergency:

Client Signature:

Print Name:

Date:

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Referred by/ how did you hear about my services?

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □ Yes □ No

Have you had previous psychotherapy?
□No □Yes, at Previous therapist's name

Are you currently taking prescribed psychiatric medication (antidepressants or others)? □Yes □No If Yes, please list:

If no, have you been previously prescribed psychiatric medication?
□Yes □No If Yes, please list:

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams □ Other

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4. How many times per week do you exercise?
Approximately how long each time?

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting Have you experienced significant weight change in the last 2 months?
□ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes

7. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Rarely □ Never

8. Have you had suicidal thoughts recently (i.e. within the past two weeks)?

□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes

If yes, how long have you been in this relationship?

On a scale of 1-10, how would you rate the quality of your current relationship?

10. In the last year, have you experienced any significant life changes or stressors:

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OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes
If yes, who is your current employer/position?

If yes, are you happy at your current position?

Please list any work-related stressors, if any:

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes
If yes, what is your faith?

If no, do you consider yourself to be spiritual? □ No □ Yes

OTHER INFORMATION (to be completed in session):

Current Issues (Why counselling? Why now?)

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What do you consider to be your strengths?

What are effective coping strategies do you use?

What are your goals for therapy?

(Recommendations/next steps/homework):

Client Signature:_____

Date:_____

Therapist Signature:_____

Date: _____