T 807 621 0906
E INFO@MONIQUEGOUTHRO.COM

Introductory Interview (Minor)

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:
_____

Name of parent/guardian (if you are a minor):

_____

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

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:

Parent/ Guardian Signature:

Print Name:

Date:

Referred by/ how did you hear about my services?

Is your child currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □ Yes □ No

Has your child had previous psychotherapy?
□No □Yes, at Previous therapist's name

Is your child currently taking prescribed psychiatric medication? □Yes □No

If Yes, please list:
If no, has your child been previously prescribed psychiatric medication?
□Yes □No If Yes, please list:

HEALTH AND SOCIAL INFORMATION

1. How is your child's 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, diabetes, etc.):

3. Is your child having any problems with his/her sleep habits? □ No □ Yes

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

□ Other

4. What types of extra-curricular activities is your child involved in?

5. Is your child having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

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Has your child experienced significant weight change in the last 2 months? □ No □ Yes

6. What school does your child attend? Grade?

7. Has your child ever engaged in self-harm behaviours and/or made statements related to self-harm or suicide?

8. In the past year, has your child experienced any significant life changes or stressors (i.e. moving to a new school, death of a family member, separation or divorce of parents)?

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

FAMILY INFORMATION:

Who lives in the family home? (Names and ages of siblings)

RELIGIOUS/SPIRITUAL INFORMATION:

Are there any religious or spiritual beliefs I should be made aware of?

OTHER INFORMATION (can be completed in session):

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Current Issues (Why counselling? Why now?)

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What do you consider to be your child's strengths?

What effective coping strategies des your child use?

What goals would you like to see addressed in therapy?

Client Signature:_____

Date:_____

Therapist Signature:_____

Date: _____