Client Information Form
Appin Counselling

Name: _____ Pronouns used: _____

Date of Birth: _____

Phone number : _____ Do you prefer text or call: ____ Can we leave a message: Y / N

Email address: _____

Emergency contact: _____

Family doctor or physician: _____

Consent to share information? _____ Contact:_____

Are you currently seeing a psychiatrist? _____ Name: _____

Consent to share information? _____ Contact:_____

Have you had previous counselling or psychiatric care? _____

Any current medications or medical concerns that could impact counselling: _____

_____

_____

Please tell us a bit about what brought you into counselling: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____