

## Lotus Counselling

*The information you provide on this form will not be disclosed to anyone (including those who may attend counseling with you), and will be kept as part of your confidential file. It is not required that you answer all questions; however, your thorough completion of the questionnaire is strongly encouraged, as your responses enable me to make a more thorough, focused assessment and support more efficient treatment planning.*

Today's Date \_\_\_\_\_

### **GENERAL INFORMATION**

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
(May we leave a message for you here? yes no) (May we leave a message for you here? yes no)

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Are you content in/with your current employment? very moderately very little not at all not sure

Work Phone \_\_\_\_\_ Preferred Email Address: \_\_\_\_\_  
(May we leave a message for you here? yes no) (May we contact you here? yes no)

If contact is necessary (for appointments, etc.) which number do you prefer: home work cell other \_\_\_\_\_

Last year of school completed: 9 10 11 12 GED College/University: 1 2 3 4 Graduate : 1 2 3 4 5 6

Certificate/Diploma/ Degree pursued/accomplished \_\_\_\_\_

### **RELATIONAL INFORMATION**

Current Relationship Status single exclusively dating engaged married living together common-law  
(check all that apply) separated divorced widowed

If in committed relationship, for how long? \_\_\_\_\_ How long have you known your partner? \_\_\_\_\_

Partner's Name: \_\_\_\_\_ Partner's Age: \_\_\_\_\_

Number of previous marriages for you? \_\_\_\_\_ For your partner? \_\_\_\_\_

If widowed, separated, or divorced, for how long? \_\_\_\_\_

With whom do you currently live? Alone Spouse Children Parent(s) Sibling(s) Boyfriend  
(check all that apply) Girlfriend Other (please specify) \_\_\_\_\_

### **PHYSICAL HISTORY**

Please list any conditions, illnesses, treatments, or surgeries (including pregnancies, or related treatments) that might be relevant to your reason for seeking counseling: \_\_\_\_\_

\_\_\_\_\_

Please list all current medications you are taking, and the reasons. (List even if you seldom use, or take only as needed.)

_____	_____	which improves/controls _____	_____
(medication)	(dosage)		(since)
_____	_____	which improves/controls _____	_____
(medication)	(dosage)		(since)

**PRESENTING ISSUES AND GOALS**

Please describe briefly why you are coming to counseling? (i.e., what are your issues, problems?) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you hope to gain or change by coming for counseling? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long do you believe counseling should last? \_\_\_\_\_

Have you had any previous counseling, psychiatric treatment, or residential/in-patient care?   no   yes.

Please indicate on the scale below how distressing your problem(s) are to you. Place an "X" on the line.

\_\_\_\_\_

Slightly Distressed	Moderately Distressed	Extremely Distressed
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Are you currently experiencing any suicidal thoughts?   Yes   No

Over the past several years, have you frequently experienced suicidal thoughts?   Yes   No

Have you attempted suicide in the past?   Yes   No   When? \_\_\_\_\_

Have any of your friends or family ever committed or attempted suicide?   Yes   No