



Max Brown BA (Hons) psychology  
Specialist wellness counsellor  
ASCHP licence number: SWC21/992

### Client Information & Consent

Date \_\_\_\_\_

#### Section A. 1 – Personal Information- client

Client (legal) Name \_\_\_\_\_

Preferred name and pronouns \_\_\_\_\_

Age \_\_\_\_\_

Residential  
Address \_\_\_\_\_

Postal Address \_\_\_\_\_

Phone (WhatsApp capable) \_\_\_\_\_

Alternate number \_\_\_\_\_

Email \_\_\_\_\_

Education:

- ☐ Primary school  
☐ Technical college

- ☐ High school  
☐ Other \_\_\_\_\_

#### Section A. 2 – Personal Information- parent/ guardian

Parent/ guardian (legal) Name \_\_\_\_\_

Preferred name and pronouns \_\_\_\_\_

I.D. Number \_\_\_\_\_

Residential  
Address \_\_\_\_\_

Postal Address \_\_\_\_\_

Phone (WhatsApp capable) \_\_\_\_\_

Alternate number \_\_\_\_\_

Email \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Education:

- ☐ High school  
☐ Technical college  
☐ Under grad degree

- ☐ Post grad degree  
☐ Other \_\_\_\_\_

**Section B – Marital Status= parent/ guardian**

- ☐ Single  
☐ Engaged  
☐ Married (Duration \_\_\_\_\_)  
☐ Civil partnership (Duration \_\_\_\_\_)  
☐ Separated (Duration \_\_\_\_\_)  
☐ Divorced (Duration \_\_\_\_\_)

If married/ civilly partnered;  
Number of times married/ civilly partnered \_\_\_\_\_

Partner's Name, and pronouns \_\_\_\_\_

Partner's Occupation \_\_\_\_\_

Partner's Education:

- ☐ High school  
☐ Technical college  
☐ Under grad degree

- ☐ Post grad degree  
☐ Other \_\_\_\_\_

**Section C – family members and Roommates**

Name	Age	Gender and pronouns	Relationship	Live with you (Y/N)


### Section D – Counselling History

Any previous counselling?

☐ Yes

☐ No

If yes, when? \_\_\_\_\_

Where? \_\_\_\_\_

With whom? \_\_\_\_\_

Why? \_\_\_\_\_

Are you, or another family member, currently seeing another mental health professional?

☐ Yes

☐ No

If so, which family member? \_\_\_\_\_

Name of professional \_\_\_\_\_

For what purpose? \_\_\_\_\_

### Section E – Emergency contacts

Person to contact in emergency

Name	Relationship	Address	Cell Phone

### Section F – Current Situation

PLEASE FILL OUT THE FOLLOWING INFORMATION AS IT APPLIES TO THE CLIENT

State the nature of the problem in your own words.

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What is your most difficult relationship right now? \_\_\_\_\_

What is your most difficult emotion right now? \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

### Section G – Medical Information

Doctor's name \_\_\_\_\_

Doctor's address \_\_\_\_\_

Doctor's phone no \_\_\_\_\_

Are you presently taking any chronic medication?

☐ Yes

☐ No

If so, list please \_\_\_\_\_

\_\_\_\_\_

For what purpose/s? \_\_\_\_\_

\_\_\_\_\_

Are you presently taking any other medication?

☐ Yes

☐ No

If so, list please \_\_\_\_\_

\_\_\_\_\_

For what purpose/s? \_\_\_\_\_

\_\_\_\_\_

Are you presently taking any supplements/natural/traditional medication?

☐ Yes

☐ No

If so, list please \_\_\_\_\_

For what purpose/s? \_\_\_\_\_

\_\_\_\_\_

**Section H = Common problem/symptom checklist.**

(Fill in: 0 – none, 1 – mild, 2 moderate, 3 – severe)

	Parent(s)		Siblings		Irritability
	Feeling misunderstood		Being single		Disability
	Alcohol/drugs		Other addictions		Co-dependency
	Grief/loss		Sexual issues		Intimacy
	Abortion		Bullying		Loneliness/isolation
	Past hurts		Church		Children at school
	Family		Discrimination		Life changes
	School/learning		Spiritual		Easily distracted
	Fear		Weight control/change		Puberty
	Anxiety		Trauma		Social skills
	Low self-esteem		Crisis		Conflict
	Mood swings		General unwellness		Loneliness
	Anger		Sexual orientation		Gender identity
	Self-control		Physical illness		Friends
	Stress management		Body image concerns		Uncertainty
	Fatigue		Sadness/depression		Hopelessness
	Impulsiveness		Violent behaviour		Disorganized thoughts
	Sleeping difficulties		Nightmares		Other

Are there any special circumstances related to your childhood that you would like to note now? (Adoption, separation, divorce, etc.)

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Were you raised with any particular religious or cultural beliefs?

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Any note you would like to add:

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Signature (client) \_\_\_\_\_ Date \_\_\_\_\_

Signature (parent/ guardian ) \_\_\_\_\_ Date \_\_\_\_\_

**This form will be reviewed with the client during our first session in order to determine their best path forward.**

**All information provided here is protected under the confidentiality clause found in the Service agreement.**

**Be sure you review and sign the terms and conditions detailed in your Service Agreement, and to submit the Indemnity form along with these documents.**

**Thank you for your time.**