



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

Client Information & Consent

Date _____

Section A – Personal Information

Client (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

- ☐ 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)	Dependent on 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.

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)

	Marriage		Pre-marital		Child custody
	Divorce/separation		Being single		Disability
	Alcohol/drugs		Other addictions		Co-dependency
	Grief/loss		Sexual issues		Intimacy
	Abortion		Miscarriage		Infertility

	Past hurts		Church		Children
	Family		Discrimination		Life changes
	School/learning		Spiritual		In-laws
	Fear		Weight control/change		Parents
	Anxiety		Work/career		Communication
	Low self-esteem		Money/budgeting		Conflict
	Mood swings		Employment		Loneliness
	Anger		Trauma		Aging/dependency
	Control		Crisis		Friends
	Stress management		General unwellness		Uncertainty
	Fatigue		Sadness/depression		Hopelessness
	Impulsiveness		Violent behaviour		Disorganized thoughts
	Sleeping difficulties		Nightmares		Easily distracted
	Irritability		Loneliness/isolation		Body image concerns
	Sexual orientation		Gender identity		Physical illness

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

Were you raised with any particular religious or cultural beliefs?

Any note you would like to add:

I _____ confirm that I completed the form honestly and truthfully to ensure the best possible outcome for our therapeutic relationship.

Signature _____ Date _____

This form will be reviewed with you during our first session in order to determine your 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.

Thank you for your time.