Doug Cochrane, MSW ▪ 705-796-7759 ▪ doug@foundationtherapy.ca

Introductory Interview (Adult)

Please provide the following information for our records. Leave blank any question you would rather not answer at this time. Information you provide here is held to the same standards of confidentiality as our therapy.

Name: ____

Birth Date: __________/__________/__________ Age: ________ Gender: ______________

Marital Status:

- ☐ Never Married
- ☐ Partnered
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Number of Children: ____________________ And Current Ages ____________________

Local Address: ____

____

Home Phone: ______________________________ May we leave a message? ________

Cell/Other Phone: ______________________________ May we leave a message? ________

Email: ______________________________ May we email you? __________

Emergency Contact: (name, relationship, phone number)

____

I, the undersigned, give permission for Foundation Therapy Services to contact the above person in the event of an emergency:

Client Signature: ____

Print Name: ____ Date: ______________

1. Were you referred to, or how did you find Foundation Therapy Services?

2. Are you currently receiving psychiatric services, professional counselling or psychotherapy services elsewhere? If so, list services.

3. Have you previously, or are you currently taking psychiatric or doctor prescribed medication, including medicinal marijuana? If so, please list.

Health and Social Information

4. How is your physical health at the present? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

5. Please list any persistent physical symptoms or health concerns (i.e. chronic pain, headaches, high blood pressure, diabetes, etc.):

6. Are you experiencing problems or changes with your sleep habits? _________________

If Yes, please check where applicable:

- □ Sleeping Too Little
- □ Sleeping Too Much
- □ Poor Quality Sleep
- □ Disturbing Dreams
- □ Other

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7. Do you exercise and if so, what do you do?

8. Are you having any difficulty with appetite or eating habits? ____________________________________

If yes, are you eating less_________, eating more__________ or binging____________?

Have you experienced significant weight change in the last two months__________?

9. Do you regularly consume alcohol? ____________ Number of drinks per week? _______________

10. How often do you engage in recreational drug use?

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Rarely
- ☐ Never

11. Have you had suicidal thoughts recently and/or at any time in your life?

12. What do you remember about your childhood that was happy, sad and/or traumatic?

13. Are you currently in a romantic relationship? _________ For how long _________________________

On a scale of 1 to 10 how would you rate that relationship. ______________ (10 being the best.)

14. In the last year have you experienced any significant life changes or stressful issues?

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Occupational Information

15. Are you currently employed? ___________

If yes, who is your current employer and what is your position?

16. If working, are you happy at your current occupation? ____

17. Please list any work-related stress issues that may be occurring?

Religious/Spiritual Information

18. Do you consider yourself to be religious? __________________

If yes, what faith do you practice?

19. If no, do you consider yourself to be spiritual? ____

Other Information

20. Why do you think you need counselling? Why now? ____