



Shalom Counselling Centre of Alberta
20 Trinity Close, Red Deer, Ab. T4P 0R1
info@shalomcounselling.com

Ph: 403.342.0339
Fax: 403.314.1798
www.shalomcounselling.com

BACKGROUND INFORMATION FORM

Welcome to Shalom Counselling Centre of Alberta. Please complete the following Background Information Form to the best of your ability. You are not required to answer all of the questions; however, the more you do the better we are able to help you. Each person involved in counselling is asked to fill out a form individually so we can hear each point of view. All information collected is strictly confidential and will only be shared with the Shalom Team as needed.

Today's Date: _____	
First and Last Name: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary Age: _____ Date of Birth (dd/mm/yr): _____
Cell Phone: _____	Home Phone: _____
Business Phone: _____	Email: _____
Address _____ City _____ Postal Code _____	
Best way to contact or leave message about appointments: <input type="checkbox"/> Do not leave a message with anyone but me <input type="checkbox"/> Please contact me by email <input type="checkbox"/> Ok to leave message on answering machine <input type="checkbox"/> Other: _____	
Emergency Contact Information: (only used in the event of threat to safety) Name: _____ Phone: _____ Email: _____	
Relationship Status <input type="checkbox"/> Single <input type="checkbox"/> Dating <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Prefer not to say	
Type of Counselling requesting: <input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Family (If couple or family is being requested, please include name(s): _____)	
If couple or family counselling is being requested, please indicate who will join you in your counselling: <input type="checkbox"/> Partner <input type="checkbox"/> Child/Children <input type="checkbox"/> Siblings <input type="checkbox"/> Parents <input type="checkbox"/> Other Family <input type="checkbox"/> Other	
My Primary Reason for Counselling: <input type="checkbox"/> Individual/Personal Growth <input type="checkbox"/> Family/Relational Reasons	Counselling Location: <input type="checkbox"/> Red Deer Office Location <input type="checkbox"/> I prefer ZOOM video counselling

Do you have a Health Benefit Plan? ☐ Yes ☐ No
If yes, with whom: _____

Are you requesting a certain counsellor?
If yes, with whom: _____

What is your gross annual household income? \$ _____

(Please note that fees are assessed on your gross annual income. We will require you to show proof of income at your first appointment either by paystubs or annual tax return)

Where do you live?

☐ I live by myself ☐ I am new to my community this year ☐ I live in a household with others
☐ I am new to Canada in the last 3 years

Presenting Concerns:

<input type="checkbox"/> Addiction	<input type="checkbox"/> Adjustment and Recovery	<input type="checkbox"/> Anger Management
<input type="checkbox"/> Boundaries/Self Care	<input type="checkbox"/> Communication	<input type="checkbox"/> Conflict Management
<input type="checkbox"/> Coping Skills	<input type="checkbox"/> Domestic Abuse	<input type="checkbox"/> Health and Wellness
<input type="checkbox"/> Healthy Eating Habits	<input type="checkbox"/> Lifestyle/Behavioral Changes	<input type="checkbox"/> Marriage Preparation
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Navigating Grief/Loss	<input type="checkbox"/> Parenting Strategies
<input type="checkbox"/> Problem Habits	<input type="checkbox"/> Problem Solving	<input type="checkbox"/> Relationship(s)
<input type="checkbox"/> Safety and Well-being	<input type="checkbox"/> Self-Acceptance	<input type="checkbox"/> Self Image and/or Identity
<input type="checkbox"/> Spiritual Health/Growth	<input type="checkbox"/> Stress Management	<input type="checkbox"/> Trauma
<input type="checkbox"/> Other (if other, please specify: _____)		

How would you score your current level of distress?

☐ 1 (Mild) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Severe)

Has your current distress included thoughts or actions of suicide?

☐ Yes ☐ No

Has your current distress included thoughts or actions of self harm?

☐ Yes ☐ No

Are there risk or time factors adding to the urgency of your counselling?

☐ Yes ☐ No

Do your counselling goals include a spiritual perspective?

☐ Yes ☐ No

Do your counselling goals include a cultural perspective?

☐ Yes ☐ No

Do you feel currently you have supportive relationships in your life?

☐ Yes ☐ No

Are there health conditions that may impact your counselling goals?

☐ Yes ☐ No

Have you ever received a professional diagnosis and/or treatment for a mental health condition?

☐ Yes ☐ No

Have you or others had concerns about your use of drugs or alcohol?

☐ Yes ☐ No

If you feel at risk right now of actions of harm, self-harm or actions of suicide, support is available 24/7:
Mental Health Distress Line 877.303.2642
Suicide Help Line 800.232.7288
Women's Emergency Shelter 888.346.5643