Shalom Counselling Centre

Welcome to Shalom Counselling Centre of Central Alberta. Please complete the following *Background Information Form*. You are not required to answer all of the questions; however, answering all relevant questions allows us to be of more help. Each person involved in counselling is asked to fill out a form individually, so we can hear each point of view. If you require more room for your information please use additional pages. Your privacy is respected at Shalom; the information collected is treated with high professional standards of confidentiality and will only be shared with the Shalom team as required to serve you.

| | | |
|---|---|---|
| **Last Name:** | **First Name:** | **Today's Date:** DD / MM / YYYY |
| **Gender:** | **Birthdate:** DD / MM / YYYY | **Age:** |
| **Cell Phone:** | **Home Phone:** | |
| **Email:** | | |
| **Home Address - Street Address:** | | |
| **City:** | **Postal Code:** | |

**RELATIONAL STATUS:**

☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed

**What is the best way(s) to contact/message you about appointments?**

☐ Do not leave a message with anyone but ME
☐ Please email me at above email address
☐ OK to leave message on answering machine/voice mail
☐ Only use my cell phone to leave messages
☐ Others who could receive the message include: (please specify name/relationship) _____
☐ Other (please explain):

**Where you live – please check any that apply to you:**

☐ I live on my own ☐ I am new to my community this year ☐ I am new to Canada in the last 3 years

**Your Preferences:** If you are requesting a specific counsellor, please name that counsellor:

The Shalom location I prefer: ☐ Red Deer ☐ Olds (not all counsellors are available at the Olds office)

**BENEFIT PLANS:**

If you are seeking insurance coverage from a private plan, check if they have specific requirements. Such requirements may be that you only see a therapist of their choosing, or only a therapist with very specific designations. If you have any of these specific requirements, please specify:

**The type of counselling I am requesting:**

☐ Individual Counselling ☐ Couples Counselling ☐ Family Counselling ☐ Group Therapy

Please name those joining you in counselling:

**How did you hear about SHALOM Counselling Centre?**

| | | | | |
|---|---|---|---|---|
| ☐ Internet | ☐ Website | ☐ Facebook | ☐ Newspaper | ☐ Yellow Pages |
| ☐ Relative | ☐ Friend/Neighbour | ☐ 90.5 Shine FM | ☐ Community Services Guide | |
| ☐ Church | ☐ Health Care Provider | ☐ Other (please specify): | | |

**FOR RETURNING CLIENTS:**

Which counsellor did you see previously?_____

If you had a different name during previous counselling, what was it: _____

☐ Check to confirm your permission for the counsellor to review files of your previous sessions.

# INFORMATION FOR YOUR COUNSELLOR AT SHALOM

***ISSUES and CONCERNS:*** *Please describe and number to indicate your priority.*

**How serious do these concerns seem to you?** Mild ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Severe

**Are there other risk or time factors adding to your urgency for counselling?**

**What do you hope to see changed by counselling?**

**Who should be included in the counselling if we are to find lasting solutions?**

**Do your counselling goals focus on spiritual concerns?** ☐ YES ☐ NO If YES - please explain:

**SUPPORTIVE RELATIONSHIPS:**

Who do you turn to for help and encouragement now: ☐ Spouse ☐ Friend(s) ☐ Parent(s) ☐ Work
☐ Other Family ☐ Pastor ☐ Teacher ☐ Other (specify):

**HISTORY OF MAJOR LOSSES:**

Please list by year any deaths, prenatal losses, major upsets or significant changes that have impacted you or your immediate family.

**EMPLOYMENT:**

| | | |
|---|---|---|
| Occupation: | | Present Employer: |
| Average Hrs. / Week: | Length of Employment: | Specialized Training: |
| Any job changes this year? ☐ YES ☐ NO | Level of job satisfaction: High ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 Low | |

**RELATIONSHIP HISTORY:**

| | | |
|---|---|---|
| ☐ Marriage ☐ Common Law ☐ Dating | | |
| Partner's Name: | Age: | Phone: |
| Length of time dating: _____ Years _____ Months | Length of Marriage or Common Law: _____ Years | |
| Have you ever separated? ☐ YES ☐ NO If Yes, when and for how long? | | |
| Have you or your partner been previously in other married/common law relationships? | | |
| Yours | Those of your current partner | |

**PLEASE LIST YOUR FAMILY:** parents, siblings, step parents/step siblings, others you consider family

| NAMES OF YOUR FAMILY | RELATIONSHIP | AGE | WHERE THEY RESIDE | FREQUENCY OF CONTACT |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| YOUR CHILDREN'S NAMES | SON/DAUGHTER | AGE | WHERE THEY RESIDE *With you and/or elsewhere* | FREQUENCY OF CONTACT |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**FAMILY OF ORIGIN HISTORY:**

**In the home you grew up in was there?** ☐ Alcohol/Drug Abuse ☐ Emotional Abuse ☐ Physical Abuse ☐ Sexual Abuse ☐ Mental Illness ☐ Chronic Illness

**COUNSELLING HISTORY:**

**Have you seen anyone for counselling before?** ☐ YES ☐ NO If YES, please fill out the information below:

| COUNSELLOR / AGENCY | YEAR | # of SESSIONS | TYPE OF ISSUE(S) | VALUE OF COUNSELLING |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**MEDICAL INFORMATION:**

**Rate your health:** ☐ Good ☐ Average ☐ Poor ☐ Declining ☐ Improving

**Are there any health conditions that may impact your counselling concerns?** ☐ YES ☐ NO If YES, please explain:

**Have you ever received a diagnosis and/or treatment for a mental health condition?** ☐ YES ☐ NO If YES, please specify:

| **Have you noticed any of the following:** | YES | NO | PLEASE EXPLAIN |
|---|---|---|---|
| Weight loss / gain | | | |
| Change in sleep patterns | | | |
| Change in sexual life | | | |
| Self abusive thoughts/actions | | | |
| Suicidal thoughts/actions | | | |

**MEDICATIONS:** Are you presently taking any medication? ☐ YES ☐ NO If YES, please list below:

| NAME OF MEDICATION | DOSAGE | LENGTH OF USE | PURPOSE OF MEDICATION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

How often do you use alcohol? ☐ NEVER ☐ OCCASIONALLY ☐ WEEKLY ☐ SEVERAL TIMES A WEEK

How often do you use other drugs? ☐ NEVER ☐ OCCASIONALLY ☐ WEEKLY ☐ SEVERAL TIMES A WEEK

Has anyone expressed concern for your alcohol or drug use? ☐ YES ☐ NO If YES, who?

**The focus of counselling I am requesting:** (check as many boxes as may apply)

| | | |
|---|---|---|
| ☐ Improved Interpersonal Skills | ☐ Increased Coping Skills | ☐ Improved Relationship(s) |
| ☐ Stress Management | ☐ Lifestyle/Behavioural Changes | ☐ Improved Mental Health |
| ☐ Safety and Well Being | ☐ Adjustment and Recovery | ☐ Parenting Concerns |
| ☐ Problem Solving | ☐ Anger Management | ☐ Strengthening Communication |
| ☐ Spiritual Issues | ☐ Marriage Preparation | ☐ Addressing Addictions |
| ☐ Other please specify: | | |
| My primary reason for counselling: | ☐ Individual/Personal Growth | ☐ Family/Relational Reasons |

**COMPLETED FORMS:**

Completed printed forms should be marked **"Confidential"** and mailed, emailed or faxed to Shalom using the contact information below. For further information, contact us at 403.342.0339.

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