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:

Forms completed online are forwarded to our office by pressing submit.
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.

SHALOM COUNSELLING CENTRE
5515 - 27 Avenue
Red Deer, AB T4P 0E3
Fax 403.314.1798
info@shalomcounselling.com