**Pre-Therapy Assessment Form:**

The purpose of this form is to help me understand what you’re seeking from therapy and how you feel therapy might help you. This information helps to ensure that I am the right therapist for you and that I am able to meet your needs as a client. Please answer the following information truthfully and as thoroughly as possible. If I feel I cannot help you, I will try my best to connect you with someone who can.

**Your Details:**

**Your Name:**

**Your Telephone Number:**

**Email Address:**

**Are you currently or have your previously been under the care of a psychiatrist or another mental health professional within the last 12 months?**  Yes  No

**Please specify:**

**Have you been professionally diagnosed or self-diagnosed with any of the following conditions?**

Autism / Asperger’s  ADHD / ADD  Sensory Processing Disorder

**Appointment Preferences:**

**What is your availability? (check all that apply)**

*\*Please note that I am currently only able to offer sessions Monday-Wednesday\**

|  |  |  |
| --- | --- | --- |
| **Monday** | **Tuesday** | **Wednesday** |
| Morning | Morning | Morning |
| Afternoon | Afternoon | Afternoon |
| Evening | Evening | Evening |

**What type of counselling support are you seeking? (select one)**

|  |  |
| --- | --- |
| Zoom (video) | Email Correspondence only |
| Zoom (audio only) | Live Chat (via Zoom) only |
| In-Person |  |

**Therapy Expectations:**

**What is your preferred *frequency* of sessions? (select one)**

Once a week  Bi-weekly

Monthly  Twice a week

Not sure

**What are your expectations for the *length* therapy? (select one)**

Short-term work (2-6 months)  Intermediate (6 months-1 year)

Long-term work (1+ years)  Unsure

**Please briefly describe what brings you to therapy and how you feel therapy might help you:**

**Personal History:**

**Did you experience something very difficult in your past?**  Yes  No

**Do you still sometimes think about this event / situation?**  Yes  No

**Have you had therapy before?**  Yes  No

**Please select any of the following concerns that are relevant for you:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| depression | life transitions | family issues | violence/victim support | problems with food/disordered eating | shyness/social phobia | abuse |
| panic attacks | anxiety | feeling stressed or overwhelmed | bereavement/ death of a loved one | trauma | thoughts of suicide | medical illness |
| anger | addiction | low mood | feeling emotionally numb/ empty | sexuality | body image | PTSD (post-traumatic stress) |
| low self-esteem | problems at work or school | self-harm | troubled relationships | trouble relating to others | risky behaviour | self-discovery |
| gender identity | childhood issues | nightmares or flashbacks | paranoia | fears/phobias | general unhappiness | terminal illness |