**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 |