Dr. Anna Baranowsky Today's Date: _____

CONFIDENTIAL CLIENT RECORD

Note: If you are a parent filling this out for your child, please use your child's name, birthdate etc.

Name: _____ Date of Birth ____/____/_____
Day/Month/Year

Name: _____ Date of Birth ____/___/____
Day/Month/Year

Name: _____ Date of Birth ____/___/____
Day/Month/Year

ADDRESS: _____

_____POSTAL CODE: _____----_____

Telephone: ( ) ____ - _____(home) May we leave a message here? Y/N

( ) ____- _____(business) May we leave a message here? Y/N

( ) ___- _____(cell) May we leave a message here? Y/N

Email address: _____

OCCUPATION: _____

Current Employment/Employer: _____

Who referred you to this service?

Name: _____

Telephone:( )_____ - _____ May we contact this person to thank them for the referral? Y/N

Family Physician: Same as Referral Y/N (If YES, please skip this section)

Name: _____

Telephone: ( ) _____- _____ May we contact this person to tell them about our services? Y/N

Continued on next page

Please describe any current medical problem(s):

_____
_____
_____

Are you currently taking any medication(s)?:

_____
_____
_____

In the past, have you had counselling or been treat/assessed by a mental health professional?

Y/N If YES: When: _____

Reason:_____

Marital Status:	Single/Never Married	_____
	Married	# years/months: _____
	Common-law	# years/months:_____
	Separated	# years/months:_____
	Divorced	# years/months:_____
	Widowed	# years/months: _____

Family Information: (Please list first names only, where applicable)		(approximate age) (Marked "D" is deceased)
Spouse/Partner:	_____	_____
Children:	_____	_____
	_____	_____
	_____	_____
	_____	_____
Mother:	_____	_____
Father:	_____	_____
Siblings:	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Who currently lives with you? _____