WESTMOUNT
PSYCHOLOGICAL
SERVICES

Wellness in mind

PERSONAL INFORMATION

Legal name: _____

Date of Birth: _____/_____/_____

Gender (e.g. female, non-binary, questioning): _____

Pronouns used (e.g. he, they): _____

Address: _____

_____

_____

Phone: _____ Mobile: _____

Can I leave a Message? _____

E-mail: _____

Current occupation: _____

Who referred you to me? _____

Do you give me permission to thank them?

☐ Yes ☐ No If yes, please initial _____

IN CASE OF EMERGENCY:

WESTMOUNT PSYCHOLOGICAL SERVICES

Wellness in mind

Name: _____

Phone: _____ Mobile: _____

Relationship: _____

BRIEF HISTORY

1. Have you had previous counselling, psychiatric care, etc.? ☐ Yes ☐ No

If yes, when_____

2. Do you have a general practitioner / family physician?

_____

3. Are other health professionals helping you right now?

_____

_____

4. Have you ever had a serious illness, either physical or psychological?

☐ Yes ☐ No

If yes, state for what reason & when: _____

_____

_____

5. Are you presently taking any medication? ☐ Yes ☐ No

If yes, please list:

_____

_____

_____