



WESTMOUNT
PSYCHOLOGICAL
SERVICES

Wellness in mind

PERSONAL INFORMATION

Legal name: _____

Date of Birth: ____/____/____

Gender: Female__ Male__ Questioning__ Non-binary__

Please tell us the pronoun you would like us to use: She__ He__ They/Them__

Address: _____

Phone: _____ Mobile: _____

Can I leave a Message? _____

E-mail: _____

Current occupation: _____

Who referred you to me? _____

IN CASE OF EMERGENCY:

Name: _____

Phone: _____ Mobile: _____

Relationship: _____

BRIEF HISTORY

Member of the Order of Psychologists
Province of Quebec

www.wellnessinmind.ca

4060 Sainte Catherine St. West Suite 640
Westmount, Quebec, H3Z 2Z3



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

If yes, when _____

2. Do you have a general practitioner / family physician? ☐ Yes ☐ No

If yes, their name: _____

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:

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