PATRICIA TURNER COUNSELLING AND CONSULTATION INC.

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Clinical Psychologist
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Tel (403) 700-1776 Fax (844)-202-3964

New Client Information

Name: ______________________________ Date of birth: ______________________________

Marital status: ______________________________ Occupation: ______________________________

Address: ____

Postal code: ____

E-mail: ____

Phone no.: Home: __________________________

Business: __________________________

Cell: __________________________

Please indicate whether a telephone message can be left at any of these numbers:

( ) Home ( ) Business ( ) Cell

Referral source: Physician: ____________________ Internet: ____________________

Friend: ____________________ Other: ____________________

Emergency contact: Name: ____________________ Relationship: ____________________

Address: ____________________ Phone: ____________________

Physician: Name: ____________________ Phone: ____________________

Many physicians prefer to be informed about their patient's involvement and progress in therapy. Would you like me to discuss your participation in therapy with your physician?

( ) Yes ( ) No

Please list any medications you are taking.

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Please be as specific as you can as you answer the following questions.

1. What are your main concerns?

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2. What do I need to know about you to better understand your situation?

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3. What are your expectations for therapy? What are your goals?

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4. Approximately how many sessions do you expect this to take?

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5. Do you have any questions or concerns about therapy?

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6. How will you know you have successfully finished therapy?

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