JILLIAN PEDRICK, MTC, RPC, RCS, Nd, NHC
CLIENT INFORMATION FORM

A. Contact Information

Name: _____ Date: _____ Male ☐ Female ☐

Email: _____DOB: _____/_____/_____ (mm/dd/yy)

Status: Single☐ Married ☐ Common-Law ☐ Blended ☐ Separated ☐ Divorced ☐

Address:_____

City:_____ Province:_____ Postal Code: _____

Home #: _____ Message?* ☐ Cell #: _____Message?* ☐

Work #: _____ Message?* ☐ Other #:_____Message?*☐

**** Can we call you at any of the above numbers to leave messages? Please √ if ok.***

Emergency Contact's Name: _____

Cell#:_____ Relationship to you: _____

IF APPLICABLE: Partner's Name: _____

Email: _____DOB: _____(dd/mm/ yyyy)

Address:_____

City:_____ Province:_____ Postal Code: _____

Home #: _____ Cell #: _____

Work #: _____ Other #:_____

B. Session Payment Information

Credit Card Number & Signature for session payment or sessions cancelled without 48 hours notice:

#_____-_____-_____-_____Expiry: _____/_____CVC:_____

JILLIAN PEDRICK, MTC, RPC, RCS, Nd, NHC

C. Brief Client Questionnaire

Have you been in counselling before? Yes☐ No☐ If yes, when? _____(mm/yy)

Please say what your previous counselling was for: _____

_____

Do you have a family history of:

Mental Illness ☐ Serious Illness ☐ Chemical dependency ☐ Alcoholism ☐ Other ☐

Explain if applicable: _____

Do you have children? No ☐ Yes ☐ - How many ☐ Step or blended children? No☐ Yes☐ How many: ☐

Names & Ages: _____Parent: _____

Names & Ages: _____Parent: _____

Other relevant information regarding children? _____

Family Doctor: _____Tel:_____

Other Doctor, if relevant: _____Tel:_____

Medical conditions: _____

Current medications: _____

Session time preferences: Morning ☐ ☐ Afternoon ☐ ☐ Evening ☐ ☐

How did you find out about Jillian Pedrick?

Doctor's Referral ☐ Word of mouth ☐ Internet Search ☐ Psychology Today Listing ☐..An ad ☐ Other ☐

D. Consent

I hereby state that I have disclosed all of the above information freely.

Signature: _____ Date: _____