AL NAHDA MULTICULTURAL COUNSELLING

First Name: _______________ Middle Name: _______________ Last Name: _______________

D.O.B: _______________ (YY/MM/DD) Address: ____

Phone: ___________________ Email: ____

Emergency Contact Name and Phone Number: ____

Referral Source Name & Contact Information: ____

Aboriginal Origin: Yes No Do Not Wish to Specify

Culture / Heritage: ____ or Do Not Wish to Specify

Gender: ___________________________ or Do Not Wish to Specify

Sexual Orientation: __________________ or Do Not Wish to Specify

Marital Status: Single Married Common Law In a Relationship Other Do Not Wish to Specify

Family Doctor Name and Phone Number: ____

Specialists and Other Health Care Providers: Please list names, contact information, and specialty:

1. ____
2. ____
3. ____
4. ____

What are your primary concerns?

____

____

____

What might have triggered your concerns?

____

____

____

When did they start? How long have these concerns lasted?

____

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____

____

Have you ever been diagnosed with a mental illness or disorder? Yes No

If yes, please specify ____

Have you ever been diagnosed with a physical and / or medical condition? Yes No

If yes, please specify ____

____

Have you ever been diagnosed with a physical disability? Yes No

If yes, please specify ____

____

Have you ever been diagnosed with a learning disability? Yes No

If yes, please specify ____

____

Have you had any head or neck injuries? Yes No

If yes, please specify ____

____

Do you drink alcohol? Yes No

If yes,

1. How many drinks have you had in the past week? ______________________________
2. How many drinks have you had in the past month? _____________________________
3. How many drinks have you had in the past 3 months? ___________________________

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Do you use or have you ever used recreational drugs? Yes No

If yes, please specify ____

____

Do you take any medications? Yes No

If yes, please specify and include all prescription and non prescription (over the counter) medications and supplements:

____

____

Do you smoke? Yes No If yes, how often/ how much? ______________________________

Do you use other tobacco products ? Yes No If yes, please specify ________________________

Do you use caffeine? Yes No If yes, how often/ how much? ______________________________

Do you use energy drinks or other caffeine containing products? Yes No

If yes, please specify ____

Do you have any concerns about your eating behavior? Yes No

Do you have any concerns about your sexuality, sexual orientation, or sexual behaviour? Yes No

Do you have any concerns about your gender? Yes No

Have you experienced discrimination about any of the following:

Race Ethnicity Ability Gender Immigration / Status Other __________

Is there a family history of mental illness and/or addiction? Yes No

If yes, please specify ____

Are you an adult child of an alcoholic parent(s)? Yes No

Have you experienced any of the following during childhood?

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Neglect Deprivation Emotional Abuse Physical Abuse Sexual Abuse

Domestic Violence War Trauma Other Types of Violence ______________________________

Have you experienced any of the following during adulthood?

Neglect Deprivation Emotional Abuse Physical Abuse Sexual Abuse

Domestic Violence War Trauma Other Types of Violence ______________________________

Do you feel close to your family? Yes No

Do you have at least one person you feel close to? Yes No If yes, please specify ____________________

Any other sources of support (incl. friends, family, pets)? Yes No

If yes, please specify ____

____