Release Restore — Client Information

Please complete this form electronically. We will review this material in your first session. The information you share here is protected as confidential information.

There are two sections to this form. Section I *is the information I routinely collect for all new clients.* Section II *gives you the option of providing additional information if you would like me to have this information about you at this time.*

Once completed, please save this form and email it to sue@sueklassen.ca.
We will discuss this information at your first appointment.

Section I

Date: ____/____/_____

Full name: _____

Birth date: ____/____/_____

Primary phone:_____

May I call you at this number? ☐ Yes ☐ No
May I leave a message at this number? ☐ Yes ☐ No
May I text you at this number? ☐ Yes ☐ No

Other phone: _____

May I call you at this number? ☐ Yes ☐ No
May I leave a message at this number? ☐ Yes ☐ No
May I text you at this number? ☐ Yes ☐ No

Address (street, city, province & postal code): _____

_____

E-mail address: _____

May I email you? ☐ Yes ☐ No

Emergency contact:_____

What is your preferred appointment type? ☐ In person ☐ On Zoom videoconferencing

Referred by (if any):_____

What would you like to accomplish through EFT therapy? Please feel free to describe this in as much or as little detail as you like. If you have specific goals you would like to work on in therapy, you can list them here.

What do you consider to be some of your strengths?

Are there barriers might affect your ability to accomplish your therapeutic goals?

Section II

Please complete any or all of the following questions if you would like me to have this information about you. This information is protected as confidential.

Gender: ☐ Male ☐ Female Self-identify:_____

Pronouns I should use for you (e.g. he/him, she/her, they/them, ey/em/eir, etc.):_____

First name(s) of significant other(s) if applicable:_____

Please list any children and their ages, and/or other key figures in your life and their roles:

Are you currently receiving any psychotherapy services? ☐ Yes ☐ No

If yes, please describe briefly:

Are you taking any medications and/or supplements at present? ☐ Yes ☐ No

If yes, please specify:

Have you ever been given a mental health diagnosis? ☐ Yes ☐ No

If yes, please describe briefly:

Briefly list or describe any current or past significant medical illnesses or problems: ☐ N/A

Are you presently under the care of a physician? ☐ Yes ☐ No

Physician's name:_____ Phone number: _____

Are you using any other physical or emotional therapies at this time? ☐ Yes ☐ No

If yes, please describe:

How would you rate your current physical / mental health? (0 to 10, where 10 is excellent) ____/10

How would you rate your current sleeping habits? How rested do you feel?

Please describe any current difficulties you are experiencing with your appetite or eating patterns: ☐ N/A

Are you currently experiencing significant sadness or grief? ☐ Yes ☐ No

If yes, since when?

Are you currently experiencing significantly anxiety or panic attacks? ☐ Yes ☐ No

If yes, please describe briefly:

Are you currently experiencing chronic pain? ☐ Yes ☐ No

If yes, please describe briefly:

Are you, or others close to you, concerned about your use of substances such as alcohol, tobacco, marijuana, or prescription drugs, etc.? ☐ Yes ☐ No

If yes, please describe briefly:

What significant life changes or stressful events have you experienced, recently, if any?

Is there anything else you would to share about yourself at this time?