



Client Information

Please complete this form electronically. 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 review this information in your first session.

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 that 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 at this time. 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.

Who do you consider part of your support system?

Starting with your birth, briefly describe you childhood and your current relationships with your parent(s)/ guardian(s).

What strengths do you appreciate from your family of origin?

What is the history (if any) of mental health issues, substance use issues, or suicide attempts in your family (e.g. parents, grandparents, siblings, parents' siblings)?

Have you experienced physical, sexual, emotional or verbal abuse? Yes No

If yes, please describe briefly.

Have you had past suicidal thoughts, plans, or attempts? Yes No

Do you currently have suicidal thoughts, intent, or plans? Yes No

Do you currently have thoughts about harming someone else? Yes No

If yes to any of the above, please describe briefly.

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

What has helped you navigate these challenges?

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

Physician's name: _____ Phone number: _____

Are you currently receiving any psychotherapy services? Yes No

If yes, please describe briefly.

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

If yes, please describe briefly.

Are you taking any prescription medications at present? Yes No

If yes, please specify.

Please briefly describe your history of work (e.g. employment, full-time parenting, volunteer work), if any.

How do you identify culturally? What do you value about this identity?

Do you consider yourself to be spiritual or religious? Yes No

If yes, please briefly describe your faith, belief, or practice and its importance in your life.

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? (0 to 10, where 10 is excellent) ____/10

Are you currently experiencing chronic pain? Yes No

If yes, please describe briefly.

What has helped you manage your pain?

How many times per week do you generally exercise?

What types of exercise do you participate in? What do you enjoy?

How do you feel about your current relationship to acquiring/preparing and eating food?

Please describe any current difficulties you are experiencing with your appetite or eating patterns.

Are you currently experiencing significant sadness or grief? Yes No
If yes, since when?

What brings you joy?

Are you currently concerned about your finances? Yes No
If yes, please describe briefly.

Are you currently experiencing significant anxiety or panic attacks? Yes No
If yes, please describe briefly.

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

Are you, or others close to you, concerned about your use of substances such as alcohol, tobacco, cannabis, or prescription drugs? Yes No
If yes, please describe briefly.

What interests, hobbies or pastimes do you enjoy?
If you could do more of something you love, what would it be?

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