

O'SULLIVAN PSYCHOTHERAPY

~ Sheilagh O'Sullivan MACP, RP ~

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CLIENT INFORMATION AND HEALTH HISTORY

Please complete the following questionnaire regarding your health and wellness. The information contained herein is private and confidential. The information shall not be revealed to any third party without your prior written authorization.

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone number: (Main) _____ (Alternate) _____

Email address: _____

Emergency contact name: _____

Telephone number: (Main) _____ (Alternate) _____

Doctor's name, address & telephone number:

Occupation: _____ Marital status: _____

Date of birth: _____ Gender: _____

No. of children: _____ Pregnant: no ___ yes ___ how many months? _____

Do you smoke? No ___ Yes ___ How much? _____

Alcohol intake? No ___ Yes ___ How much? _____

Summarize your present mental and physical health and wellness. Please ensure you include any mental health or physical health diagnoses i.e. ADHD / Heart conditions etc.

Is there a specific issue that has brought you in for psychotherapy services and / or you wish to address in our sessions together?

Are you currently taking any prescribed medications? No _____ Yes _____

If Yes, please list what you are taking and why:

Are you currently taking any dietary supplements – vitamins, minerals etc.? No _____ Yes _____

If Yes, please list what you are taking and why:

Details of exercise you take:

Hobbies:

I, _____ have completed this questionnaire and attest that I have fully disclosed my health history and that this health history is factually correct. I agree to inform my psychotherapist, Sheilagh O’Sullivan, of any and all changes to my health and wellness including but not limited to, mental health and / or medical conditions, medications, supplements, and lifestyle changes.

Client’s signature: _____ Date: _____
(Parent/Guardian if Client is under age 18)

If Client is under the age of 18:

Name of Parent/Guardian: _____