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: _____