

**PRIYA SENROY**  
Canadian Certified Counsellor, Creative Arts Therapist

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*Please bring the form filled in when you come for the initial appointment or please arrive 30 minutes prior to fill it in the office.*

*Please fill out as much or as less you would like to. Other questions maybe asked as the sessions progress.*

*Please contact if you need more information on the session fees and insurance coverage prior to setting up appointment*

**INITIAL ASSESSMENT**

**Date:** \_\_\_\_\_

**Name** \_\_\_\_\_ **Gender:** M / F/ OTHER

**Full address with postal code**

\_\_\_\_\_

**Day Phone** \_\_\_\_\_ **Evening Phone** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_ **Email address** \_\_\_\_\_

**Is it okay to leave a message with my name (only) phone number (only) YES NO. If not then how can I reach you in case I need to?**

\_\_\_\_\_

**Marital Status:** Single      Married      Separated      Divorced      Widowed

**Emergency Contact** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**Phone** \_\_\_\_\_

**Your reason for seeking counselling at this time?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Is there anyone you want involved in your counselling? (ex: family ,friend etc.) YES NO**

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**EMPLOYED/SELF EMPLOYED**    **YES**                      **NO**  
**Job satisfaction**                      **Satisfied**    **Not satisfied**    **Need a Change**

**Have you ever been diagnosed with a learning disability? Y/N If yes, explain**

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**Have you ever been diagnosed with ADD/ADHD? Y/N**

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**FAMILY HISTORY**

**Any children?** \_\_\_\_\_

**Any siblings?** \_\_\_\_\_

**Are you a caregiver?** \_\_\_\_\_

**Have you or any member of your family experienced any of the following? (Check all that apply)**

**ADDICTIONS**

**Alcohol: Who?** \_\_\_\_\_

**Drugs: Who?** \_\_\_\_\_

**Food/Eating: Who?** \_\_\_\_\_

**Gambling: Who?** \_\_\_\_\_

**Sex/Pornography: Who?** \_\_\_\_\_

**Relationship/Love: Who?** \_\_\_\_\_

**Other Who?** \_\_\_\_\_

**EMOTIONAL PROBLEMS**

**Depression: Who?** \_\_\_\_\_

**Anxiety: Who?** \_\_\_\_\_

**Panic Attacks: Who?** \_\_\_\_\_

**Manic/Depression: Who?** \_\_\_\_\_

**Obsessions: Who?** \_\_\_\_\_

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**Suicide attempts or completion: Who?** \_\_\_\_\_

**Phobia/fears: Who?** \_\_\_\_\_

**Anger/Explosive: Who?** \_\_\_\_\_

**Other: Who?** \_\_\_\_\_

**Have you or any member of your family been hospitalized for any of the above? Yes No**  
**If yes, Who?** \_\_\_\_\_

**ABUSE: (to self/family member)**

**Physical: Self/Family? By whom?**

\_\_\_\_\_  
**Emotional: Self/Family? By whom?**

\_\_\_\_\_  
**Sexual: Self/Family? By whom?**

\_\_\_\_\_  
**Spiritual: Self/Family? By whom?**

\_\_\_\_\_  
**Did you ever witness violence in your home or elsewhere while growing up? Yes No If yes, explain**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHYSICAL, PSYCHOLOGICAL AND SOCIAL HISTORY**

**List any current or past medical conditions** \_\_\_\_\_

\_\_\_\_\_  
**List all current medications (purpose)**

\_\_\_\_\_  
**Do you drink alcohol? If yes, how much and how often?**

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**Do you smoke cigarettes or chew tobacco? If yes, how much and how often?**

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**Do you consume caffeine? If yes, how much and how often?**

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**List any allergies**

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**List past use of medications for depression, anxiety, ADD/ADHD, sleep, weight control, smoke cessation, etc.?**

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**PREVIOUS COUNSELING**

**Have you ever had formal counselling? How many times?**

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**What type?**

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**When?**

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**Why?**

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**Was it inpatient or outpatient?**

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**Were issues resolved, if not, Explain**

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**Describe the last major change in your life**

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**Describe any losses that you have experienced (i.e. health issues, death, divorce, pregnancy loss, retirement, moves, etc.)**

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**CURRENT SYMPTOM CHECKLIST:**

**Are you currently experiencing any of the following? Please Check**

Anxiety/Nervousness  Anger  Bad dreams/nightmares  Compulsive Behaviors  Crying often  Depression  Easily Annoyed  Violent Thoughts  Mood Swings  Loneliness  Loss of Hope  Trouble Managing Money  Obsessive Thoughts  Problems in Relationships  Weight Loss or Gain  Racing Thoughts  Sexual problems  Panic Attacks  Trouble Concentrating  Trouble Sleeping  Irritable Bowel  Work Problems  Fatigue  School Problems  Headaches  Low Self Esteem  Social Withdrawal  Backaches  Seizures  Restlessness Other:

**SOCIAL HISTORY**

**Do you have people in your life that you consider close friends?**

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**When going through a difficult experience in your life do you have someone to confide in?**

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**What activities/hobbies do you enjoy participating in?**

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**Are you a member of any groups or organizations? Explain**

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**List two strengths about yourself**

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**List two things about yourself that you would like to change?**

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**How do you deal with stress or any of your issues that bothers you?**

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**Do you have goal setting plan? YES NO. If Yes, please describe it.**

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**Would you be interested in using any creative expressive medium like journaling or drawing in the counselling sessions? YES NO**

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**What else should your therapist know about you?**

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**\*\*\*\*I have filled out the initial assessment form to the best of my knowledge and the information will be used only for counselling purposes. I will inform the counsellor of any changes immediately to assist in the proper intervention.**

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Therapist Signature** \_\_\_\_\_ **Date** \_\_\_\_\_