



Rae Assessment, Counselling & Consultation

Michelle Rae, MSW, RSW

www.raecounselling.com

(905)301-7785

CLIENT INFORMATION

TODAY'S DATE: _____

YOUR INFORMATION:

Your Name: _____

Date of Birth: _____ Address: _____

City: _____ Postal Code: _____

Mobile #: _____ Email Address: _____

Other Additional Phone #(s): _____

Profession: _____

Relationship Status: _____

Children's Names and ages: _____

PARTNER(S) INFORMATION:

Partner(s) Name: _____

Partners Address: _____

City: _____ Postal Code: _____

Partners Age: _____

Partner(s) Health: _____

Partner(s) Profession: _____

YOUR FAMILY OF ORIGIN:

Mother/Father Names: _____

Mother/Father Location: _____

Mother/Father Health: _____

Mother/Father Profession: _____

3 Adjectives to Describe your Mother:

1 _____

2 _____

3 _____

3 Adjectives to Describe your Father:

1 _____

2 _____

3 _____



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CURRENT PROBLEM/ISSUE: Please provide description of current problems and issues to be addressed:

HEALTH CHECKLIST: Check all that apply to each family member

	YOU	PARTNER(S)	CHILD/CHILDREN
ANXIETY:			
DEPRESSION:			
DRINKING:			
DRUG USE:			
MARIJUANA USE:			
ANGER:			
WORKAHOLISM:			
DISORDERED/EMOTIONAL EATING:			
SPENDING/GAMBLING:			
GAMING:			
PORN USE:			
TRANSACTIONAL SEX: (Escorts, Massage Parlours, virtual sex, etc)			
PHYSICAL HEALTH:			

ADDITIONAL INFORMATION:

Please describe what you see to be the problem and any other issues you would like addressed

What outcome would you like to have from the counselling sessions?