Dr. Colleen Wilkie
REGISTERED PSYCHOLOGIST #1180

#26 – 1480 Foster Street
White Rock, BC V4B 3X7

BACKGROUND INFORMATION QUESTIONNAIRE

Please complete this and bring it in with you to your first session (please don't send this by email). Your completion of this questionnaire is helpful in planning how we can work together. If you have any questions leave the item and we can discuss it when we meet.

Today's Date: ____

Full Name: ____

Address: ____

____Postal Code: _____________________

Phone: (home) ______________________________ (work) ______________________________

(cell) ______________________________________

(email) ____________________________________ OK to email you to change appointment Y N
*Note – I'll respond to the address you use in your email to me OK to email you about my services Y N

Age: _______ Birth Date: _________________ Relationship Status: ___________________________

Occupation: _____________________________ Education: _________________________________

Any diversity issues you think would be important for me to know (e.g., racial, cultural, sexual/gender minority, disability/special needs, other):
____

Religion/spiritual practices: ____

Please list a person I could contact in case of an emergency:
Name: ____

Phone: (home) _______________________________ (work) _____________________________

(cell)___________________________Relationship to you: ___________________________________

604-525-9214
www.drwilkie.ca
info@drwilkie.ca

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Please list the people who live with you:
Name Age Relation to you

____

____

____

Please list other important relationships (e.g., dating relationships, friendships, family):
Name Age Relation to you

____

____

Briefly describe your reason for seeking help:

____

How did you hear about Dr. Wilkie? Select as many as apply.

___ Online search (e.g., Google)
___ BC Psychological Association
___ Counselling BC
___ Psychology Today
___ College of Psychologists of BC (regulatory body for psychology in BC)
___ Referral/recommendation from: ____
Is it okay for Dr. Wilkie to contact this person to acknowledge the referral? Y N

Who is your family physician? ____

Family physician's phone number or location of practice: ___________________________________

When were you last examined by him or her? ____

List any major health problems for which you currently receive treatment: ____________________

____

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List any medications you are now taking:

____

Any family history of mental illness or addiction? Y N
If yes, please describe:

____

Prior physical problems (including head injuries, surgeries, accidents):
Approximate dates Description Current status

____

____

What is your current caffeine intake per day? Include tea, coffee, and pop.

____

Have you ever received psychiatric or psychological help or counselling of any kind before? Y N
If you have, please describe:

Approximate dates Name of clinician Profession of clinician Reason

____

____

____

Have you ever received any substance abuse treatment or inpatient psychiatric treatment? Y N
If you have, please describe:

Approximate dates Name of program or hospital Reason

____

____

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Do you currently use alcohol or street drugs? Y N If you do, please describe:
Type of drug/alcohol Amount & frequency Increase or decrease from past?

____

____

____

Have you ever made any suicide attempts, self-destructive behaviours, violent behaviours? Y N
If you have, please describe:

Approximate dates Description Outcome (including hospital, legal issues)

____

____

____

Do you anticipate any upcoming legal matters? Y N If so, please describe:

Approximate dates Description

____

Please **circle** any of the following that you **currently** struggle with, and underline any of the following that you struggled with in the past.

depression	fears	tiredness	nervousness/anxiety
suicidal thoughts	separation/divorce	finances	drug use
friends	anger	self-control	sleep
appetite	work	relaxation	headaches

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loss	memory	ambition	remembering the past
making decisions	loneliness	inferiority problems	infidelity – self
concentration	education	hurting others	health problems
infidelity – partner	nightmares	unhappiness	marriage/relationship
children/parenting	too much energy	panic attacks	trying to lose weight
stress	my thoughts	flashbacks	avoiding people/places
guilt	changes in my life	physical pain	low energy
sexual problems	alcohol use	self-harm	shyness
difficulty trusting	body image	career choice	trauma/abuse
disability	grief	legal matters	sense of unreality
cleanliness	feeling on guard	hearing voices	checking rituals
family relationships			

Other: ____

What do you consider to be your strengths?

____

____

If you were to start therapy, how would you know that therapy has been successful?
____

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___

How many sessions do you think it would take to achieve this? ___________________________________

What might get in the way of achieving your therapy goals? _____________________________________

____

Do you have third-party coverage (e.g., extended health, insurance)? Y N If yes, please answer:

Company: ____

Type of coverage (e.g., # sessions in calendar year, what is the financial limit):

____

Is there anything else that would be important for me to know? ________________________________

____

Thank you for completing this questionnaire.