

BACKGROUND INFORMATION QUESTIONNAIRE

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: _____



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: _____



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
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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
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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.

