**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who referred you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GENERAL INFORMATION:**

**Applicant is:** Former client [ ]  New client [ ]

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Number (Primary): Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is it okay to leave a message?**  Y [ ]  N [ ]  **Best time to reach you?** Mornings [ ]  Afternoons [ ]  Evenings [ ]

**HEALTH HISTORY:**

**1. Have you been diagnosed with a mental illness****?**  Y [ ]  N [ ]  **If Yes, what is your diagnosis?**

**2. Can you tell me more about how your current mental health is impacting you?** (e.g. What areas do you feel you may need support in?)

**3. Are you prescribed medications?** Y [ ]  N [ ]  **If so, do you take them consistently as prescribed?**  Y [ ]  N [ ]

**4. Are there concerns with drug or substance use?**  Y [ ]  N [ ]  **If so, when was last use?**

**5. Is there any alcohol use?** Y [ ]  N [ ]  **If so, when was last use?**

**6. Are you experiencing any thoughts of suicide or self-harm?**

**7. Is domestic violence a concern for you or anyone in your household?**

Please submit form via:

Fax: 780-874-9957 Email: info@libbie.ca or in person during business hours