Cortney Pasternak, M.Ed, RP (Qual.), OACCPP, Counselling Services
First Session / Orientation Form

Name:_____

Address:_____

Phone Number: Cel:_____ Home: _____

Email address: _____

Can I contact you at this number? Y ___ N ___ Can I contact you at this Email: Y _____ N _____

Can I leave messages at this number? Y ____ N ____

Can I leave messages with third parties at this number? Y____ N____

Can I text at this number: Y _____ N _____

Do you regularly check messages? Email: Y: ___ N: ____ Phone: Y: _____ N: _____

For whom is the counselling service: _____

Age:_____

DOB: _____

Do you have children?: Y _____ N _____ If so, how many and what are their ages?
_____

Emergency Contact:_____
Relationship to you: _____

What is/are the main issues bringing you to counselling?
_____
_____
_____
_____
_____
_____
_____

What are your main goals for counselling? _____
_____
_____

Are you on any medications we should be aware of? _____

Do you have any serious allergies I should be aware of? _____