Katherine Ridolfo, MSW, RSW, CH
Counselling and Psychotherapy
92 Lakeshore Road, East, Suite 219
Mississauga, Ontario
L5G 4S2
E-mail: Katherine.ridolfocounselling@gmail.com
WebSite: www.ridolfocounselling.com
Phone: (416) 451-1644
OASWSSW Registration#: 827317

Please complete the following form. The protection and integrity of your information is very important-the information that you provide on this form remains confidential and protected.

Date:_____
Name:_____
_____
(First) (Last)
Date of Birth:____/_____/_____ Age:_____ Gender:
_____
(Day) (Month) (Year)
Address:_____
_____
(Street and Number) (Apartment)
_____
_____
(City) (Province) (Postal Code)
What is the best number to reach you at?_____

May we leave a message? Yes No

May we text you at this number? Yes No
E-mail:_____ May we e-mail you? Yes No

In the event of an emergency, who may we contact?
Name:_____Relationship:_____
_____
Phone Number: _____

How did you hear about me?
_____
_____

Marital Status : Single Married CIL Separated Divorced Widowed

Children? Yes No, Ages?
_____

The following questions are **OPTIONAL** but may be helpful in getting to know you better. The information that you provide, remains confidential and protected.

Are you currently or have you in the past receiving any counselling/psychotherapy services? Yes No
If yes, please describe
briefly_____
_____
_____

If you are currently taking any medications, please list names and dosages. Including any over the counter medications/supplements: N/A (Not
applicable)_____
_____
_____
_____

Have you ever been given a mental health diagnosis (Example: anxiety, depression, bi-polar, "OCD", "PTSD") ? Yes No
If yes, please describe
briefly_____
_____
_____
_____
_____

How would you rate your current health? Poor Good Very Good Excellent
Please describe or list any current or past significant medical illnesses or problems:
_____
_____
_____

How would you rate your current sleep habits? Poor Good Very Good Excellent
Please describe any sleep problems that you are currently experiencing:
_____
_____
_____

Please describe any current problems you are having with your appetite or eating patterns:
N/A
_____

_____
_____

Are you currently experiencing overwhelming sadness or grief? Yes No How long?_____
Please describe
briefly_____
_____
_____

Are you currently experiencing overwhelming anxiety or panic attacks? Do you have any phobias? Yes No
Please describe briefly:
_____
_____
_____

Are you currently experiencing chronic pain? Yes No If yes, please describe briefly:
_____
_____
_____
_____

Are you or others close to you concerned about your use of substances such as alcohol or drugs, etc.? Yes No If yes, please describe briefly?
_____
_____
_____

Have you experienced significant life changes or stressful events recently? Yes No If yes, please describe briefly:
_____
_____
_____

Is there any other information you would like to share or feel is important at this time?
_____
_____
_____
_____
_____
_____

What would you like to accomplish from your therapy sessions? You may list specific goals or describe in as many or as little detail as you like.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Are there any barriers that you think could affect your ability to accomplish your therapeutic goals?

_____
_____
_____
_____
_____
_____