Centre Famille et Ressource
Bâtir le Succès de la Communauté, Une Famille à la Fois

Family Resource Center
Building Community Success One Family At A Time

Counseling Registration Form

CLIENT INFORMATION

Name of Client _____

Date of Birth _____

Age _____

Address _____

_____

Home Phone _____

Cell Phone _____

Other Phone _____

Email Address _____

Disabilities or Conditions _____

Date of assessment: _____

Assessed by: _____

Referred to the Center by _____

Medicare Number _____ Expires: _____

Doctor's Name _____

Phone Number: _____

CLIENT QUESTIONNAIRE

1. What brought you to the Family Resource Center?

2. Which of these reasons is the most problematic?

3. How often and where does it occur?

4. Do you have a support group? Or people that you can go to for help and support? If so who and for what, describe the relationship.

5. Have you previously sought help for this issue?

   If yes, when and with who?
   If no, go to question 7

6. What interventions were administered?

7. What has worked/ helped and what hasn't?

8. What makes you want to seek help now?

9. What do you expect to gain from counseling? What would be a reasonable goal for you?

10. Is there any further information you feel would be pertinent?

11. How did you hear about us?

_____ _____

Client Signature Date