Solstice Wellness Services

Date:_____

Referred By:_____

First Name:_____ Last Name:_____

Date of Birth:_____ Gender:_____

Address:_____

Phone number: _____

Is it okay to leave a message on this phone? YES NO

Email Address:_____

Is it okay to email you for correspondence or session follow-up? YES NO

Occupation:_____ Marital Status:_____

Children (names and ages):_____

Family Doctor:_____

Medications:_____

Medical Concerns Important for me to Know:_____

Mental Health Diagnosis:_____

Do these fit for you? YES NO

History of Substance Use:_____

Emergency Contact Name:_____Phone #:_____

Previous Experience with Counselling:_____

_____

Goals/ Current Challenges:_____

_____

Other Important Information:_____

_____