

INTAKE FORM

The information you provide here is protected as confidential information. Please email the completed form to Info@BrentwoodCounselling.com

1. INTRODUCTION

| | | | |
|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------|---------------------------------------------------------------|
| Client Name | | | |
| Date of Birth | (mm/dd/yy) Age | Gender | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address | | | |
| Home Phone | May I leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Mobile Phone | May I leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Email | May I email you? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| <small>*Please note: Email correspondence is not considered to be a confidential medium of communication.</small> | | | |
| Referred By | | | |

| | | | | |
|---------------------------------|----------------------------------|------------------------------------|-----------------------------------|-------------------------------------|
| Marital Status | <input type="checkbox"/> Single | <input type="checkbox"/> Dating | <input type="checkbox"/> Engaged | <input type="checkbox"/> Common-Law |
| | <input type="checkbox"/> Married | <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced | |
| Partner's Name | | | | |
| Year of Marriage/ Common-Law | | | | |
| Year of Separation | | | | |
| Year of Divorce | | | | |
| Years Together | | | | |

| | | | | | | | | |
|--------------|--|-----|--|----------|--------------------------|-----|--------------------------|----|
| Child's Name | | Age | | at home? | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
| Child's Name | | Age | | at home? | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
| Child's Name | | Age | | at home? | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
| Child's Name | | Age | | at home? | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |

If client is under 18, please provide the following information on parent or guardian

| | |
|----------------|--|
| Name of parent | |
| Address | |
| Home Phone # | |
| Mobile Phone # | |

2. HEALTH INFORMATION

| | |
|----------------------------|-----------------|
| Physician | |
| Phone # | |
| Present Medication(s) | |
| Purpose of Medication(s) | |
| In case of emergency, call | Relation: Phone |
| Physical illnesses | |

| | |
|--------------------------|--|
| Psychiatrist | |
| Phone # | |
| Present Medication(s) | |
| Purpose of Medication(s) | |
| Mental Health Concerns | |

Are you currently attending or have attended any groups or other forms of therapy? (AA, Al-Anon, Individual, Couples, Family Therapy, etc.) Please indicate.

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3. EDUCATION, EMPLOYMENT

Please indicate your highest level of education

| | |
|--------------------------|---------------------------|
| <input type="checkbox"/> | Elementary |
| <input type="checkbox"/> | High School |
| <input type="checkbox"/> | College |
| <input type="checkbox"/> | University Undergraduate |
| <input type="checkbox"/> | University Graduate Level |
| <input type="checkbox"/> | Other (please list): |

Are you currently employed? Yes No

If yes, what is your current occupation:

4. CHURCH, COMMUNITY AFFILIATION

Do you consider yourself to be spiritual or religious? Yes No

If yes, describe your faith or belief:

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5. FAMILY HISTORY

Briefly describe your family background:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member in the space provided (self, brother, sister, father, mother, uncle, etc.)

| | Please Check | List Family Member |
|--------------------------------|----------------------------------------------------------|--------------------|
| Alcohol Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Drug Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Gambling Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Pornography/Sex Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| ADHD | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Suicide Attempts | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Domestic Violence | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Eating Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Obesity | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Obsessive Compulsive Behaviour | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Schizophrenia | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Other: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

What was the happiest or best period of your life? (describe)

What was the most difficult or tragic period of your life? (describe)

6. SELF ASSESSMENT

What are the main problem(s) as you see it?

What have you done about your problem(s) in the past or recently?

What can the counsellor do to help you?

How motivated do you feel you are to solve your problem(s)?

How will you know when your problem(s) are better?

How do you see yourself?

How do other people see you?

How would you like to be seen?

Is there any other information that you think I should know?

7. POLICIES

FEES AND PAYMENT: Fees are payable at the time of each visit, unless other arrangements have been made. You are responsible for payment regardless of third party involvement. If you fall behind in payments for more than two sessions, another session will not be scheduled until your account is paid or arrangements are agreed upon. Fees may be readjusted at any time. One month's notice will be given for any increase. I charge for time needed to prepare written reports at the hourly rate. Fees are payable by cash, credit or debit. A receipt will be issued for third party reimbursement.

CANCELLATIONS: The psychotherapy process involves meeting for a 1 hour session for individual counselling and 1.5 hour or 2 hour session for couples and families (unless other arrangements have been made). A specific time during the week has been reserved for you. If you must cancel due to illness, please notify me as soon as possible. Should you need to cancel for any other important reason, **48-hour notice is required, otherwise you will be charged for the session.** Advance notice gives me time to reschedule and allow someone on the waitlist to be seen.

TELEPHONE CALLS & EMAILS: I check my confidential email and voicemail, (604) 800.9010 daily, less frequently on weekends and holidays. For emergencies, please call 911.

CONFIDENTIALITY: Psychotherapy is confidential except where limited by Canadian law. These exceptions include situations that involve child, elder, or dependent adult abuse or if a client is a danger to him or herself or others. Written permission is otherwise needed to disclose any information to a third party. When working with children and adolescents, it is my policy to regard everything said in session as confidential except where noted above. I will encourage the child or adolescent to disclose to the parent information regarding substance abuse, sexual activity, or other behaviour that places him or her at risk.

TERMINATION: You have the right to terminate treatment at any time. It is helpful for us to discuss termination fully in at least one session. I may also terminate treatment if you do not comply with the conditions of treatment (i.e., coming to sessions clean and sober, refusal to obtain a psychiatric consult, consistent no shows). I may also terminate treatment and refer you to another professional if your issue is beyond the scope of my practice.

I understand and agree to the guidelines listed above, to the statement of confidentiality, and to paying all the charges in full at each meeting.

| Name | Date |
|------|------|
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