CREATE YOURSELF PSYCHOTHERAPY INDIVIDUAL THERAPY INTAKE FORM

To be completed by individuals ages 14+

First name: _____ Last name: _____

Age: _____ Birth day: _____ Month: _____ Year: _____

Ethnicity: _____ Religion: _____ Marital Status: _____

Sex/gender: _____ Number of children: _____ Ages of children: _____

Home address: _____

Who do you live with? _____

Cell #: _____ Home #: _____

Work #: _____ Email: _____

Name of emergency contact: _____ Phone: _____

For clients under 18 years of age:

Name of parent/legal guardian: _____ Phone: _____

Name of parent/legal guardian: _____ Phone: _____

EMPLOYMENT INFORMATION:

☐ On sick leave, as of this date: _____ Return to work date: _____

I was: ☐ Full-time or ☐ Part-time at: _____ Position: _____

☐ Full-time at: _____ Position: _____

☐ Part-time at: _____ Position: _____

☐ Not working because: _____

ACADEMIC INFORMATION:

☐ Not attending school. Highest level completed: _____

☐ Full-time at: _____ Grade/year: _____

Program: _____ Typical grades: _____

☐ Part-time at: _____ Grade/year: _____

Program: _____ Typical grades: _____

HOW YOU FOUND THIS CLINIC:

☐ Word of mouth ☐ I'm a former client ☐ Order of Psychologists (OPQ) ☐ Psychology Today ☐ Rate MDs ☐ CJAD 800 ☐ Google, using these words: _____ ☐ Other: _____

THE REASONS FOR YOUR VISIT:

_____

_____

_____

_____

_____

How intense is your emotional distress? (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Please describe: _____

_____

Overall, **how much do the problems affect your ability to perform** at work or school, get along with others, and perform daily tasks such as chores? (Mildly disruptive) 1 2 3 4 5 (Incapacitating)

Please describe: _____

_____

When did these problems start? What was going on in your life at that time?

_____

_____

_____

_____

_____

PSYCHIATRIC AND MEDICAL HISTORY

Please list any ***psychiatric or "mental"*** problems you have been diagnosed with:

_____

_____

_____

Please list any ***medical or "physical"*** problems that you have been diagnosed with:

_____

_____

_____

Please list any **medications you currently take**, and what you take them for:

_____

_____

_____

_____

Name of **Family doctor:** _____ Phone: _____

Last check-up was during the month of: _____ Year: _____

Results: _____

_____

Name of **Psychiatrist:** _____ Phone: _____

Last visit was during the month of: _____ Year: _____

Results: _____

_____

MENTAL HEALTH TREATMENT HISTORY

Have you **ever been hospitalized for psychological or psychiatric reasons?** ☐ No ☐ Yes

If yes, please describe when and where you were hospitalized, and for which reasons.

_____

_____

_____

Please tell us about any other **mental health professionals you have consulted with in the past** (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment).

_____

_____

_____

_____

_____

_____

_____

CURRENT HABITS

Please describe your ***current*** habits in each of the following areas:

Smoking:
Gambling:
Drinking:
Drug use:
Caffeine intake:
Exercise:
Eating:
Sleeping:
Fun and relaxation:

RELATIONSHIPS

Please describe **your relationships** with each of the following people, if applicable:

Biological Mother:

Biological Father:

Step-parents:

Legal guardians:

Siblings:

Extended family:

Your children:

Friends:

Romantic partner(s):

Colleagues or classmates:

Total number of close, supportive relationships:

STRESSFUL LIFE EVENTS

Please describe any **current significant or stressful life events** that you have been experiencing:

	No	Yes	If yes, please describe
Economic problems?	☐	☐	
Difficulty accessing health care?	☐	☐	
Legal issues or crime?	☐	☐	
Cultural issues?	☐	☐	
Family conflict or lack of support?	☐	☐	
Social problems?	☐	☐	
Educational or occupational difficulties?	☐	☐	
Housing problems?	☐	☐	
Grief or bereavement?	☐	☐	
Other?	☐	☐	

What are your positive qualities and skills? What do you like about yourself? What qualities have helped you to succeed at overcoming difficulties in the past?

Please tell us about your plans for the future (career, personal, etc.)

How motivated do you feel to work on things in therapy?

What are your goals for therapy? What would you like to achieve by attending therapy?

What concerns do you have about attending therapy or working on these problems?

Is there anything else that you would like to mention?

CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES: *Clinic Copy*

This consent form explains the nature of the psychological services that you are about to receive. As consent is an ongoing process, any changes that may influence your consent will be discussed with you.

Nature of treatment: (i) Evaluation and treatment planning: Approximately 1-3 sessions, (ii) Intervention: Depends on many factors, such as the nature of your difficulties and readiness for change, (iii) Termination: Approximately 1-2 sessions, involves developing a "toolbox" of strategies that may be used to help you maintain your treatment gains and reduce the likelihood of relapse and/or reoccurrence. Treatment effectiveness varies from person to person. Discussing, working with, and changing thoughts, feelings, and behaviours may be painful and challenging at times.

Approach: Your therapist will complete an intake assessment to understand how your current difficulties may have developed and are maintained within the various contexts of your life. The results of this assessment will be shared with you, and a treatment plan will be developed including some potential goals for therapy, and the strategies that may be used to help you reach your goals. Throughout the therapy you are invited to share any concerns or questions that you may have about the therapy process. This helps the therapist to personalize the treatment strategies to better match your unique needs. *Services are by appointment only; in an emergency please call 911 or go to the emergency room.*

Fees and payment: Sessions are approximately 45-50 minutes in length. Every attempt is made to see clients on time. To work towards this goal, payment is due at the *start* of each session, and sessions are to end no later than 10-minutes to the hour. Payments can be made by cash, debit, or credit card. **TWENTY-FOUR (24) hours' notice *is required to* CANCEL OR RESECHEDULE *an appointment to avoid being billed for the full fee of the missed session*. THE ONLY EXCEPTIONS ARE UNEXPECTED ILLNESS OR EMERGENCIES.**

Confidentiality: Psychological records may include items such as personal information, progress notes, and evaluations, and will be shredded 7 years after your file has been closed. No information about you can be released to a third party without your prior written consent, or verbal consent in the case of an emergency. Exceptions include: (1) when children are under 14 years of age, and their parents/legal guardians want access to the file, (2) risk of imminent danger, such as suicide, death, risk of a child running away, or serious bodily harm to an identifiable person or group, (2) suspected or known abuse or neglect of a child or older adult, (3) unsafe operation of a motor vehicle, (4) requests ordered by a court of law or the Order of Psychologists of Quebec, or (5) access is required by other personnel (e.g., administrative staff) to carry out their professional duties. Therapists must, as soon as the interest of their client so requires, receive supervision, consult another therapist, a member of another professional order, or another competent person. Disclosure of identifying information will be minimized, and names will not be released without consent.

Mutual rights and responsibilities: The relationship must remain limited to a respectful therapeutic framework. You may refuse any therapeutic suggestions offered to you, or to suspend or cease treatment at any time without penalty. *If you decide to stop treatment for any reason, please notify your therapist so that your file can be closed and/or you can be referred to another resource. If you stop treatment without an explanation, your file will automatically be closed after 30 days.*

Consent to treatment: I have read and understood the above information, and any questions that I had have been answered. I agree with the above consent form, and freely consent to receive psychological services.

Name of client*: _____ Signature: _____ Date: _____

***For clients ages 13 and younger:**

Name of parent/guardian: _____ Signature: _____ Date: _____

Name of parent/guardian: _____ Signature: _____ Date: _____

CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES: *Client's Copy*

This consent form explains the nature of the psychological services that you are about to receive. As consent is an ongoing process, any changes that may influence your consent will be discussed with you.

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