MENTAL HEALTH – ADULT INTAKE

CONFIDENTIAL CLIENT INFORMATION

Our goal is to make the most of each appointment we have. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following information about yourself as completely and legibly as possible. If you have any concerns about the relevance of any information and wish to leave it out, please feel free to do so. This information is confidential: demographic information will be seen by 360 Wellness administrative staff and all other information will only be seen by your psychologist.

Name:_____ **Gender:** ( ) Male ( ) Female

DOB (_____/_____/_____) Age:_____ Birthplace:_____

(dd/mm/yyyy)

Address:_____

City:_____ Province:_____ Postal Code:_____

Phone: _____ may we leave a message? ( ) Yes ( ) No

Cell/Other: _____ may we leave a message? ( ) Yes ( ) No

Email: _____ may we email you? ( ) Yes ( ) No

*please note that email is not considered to be a confidential medium of communication

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MARITAL STATUS:

( ) Married ( ) Never Married ( ) Domestic Partnership

( ) Separated ( ) Divorced ( ) Widowed

Partner/Spouse's Name:_____ Age:_____ Duration of Relationship:_____

Children's name(s) and age(s):_____

_____

Person to alert in the case of emergency:_____

Relationship to you:_____ Phone:_____

How did you come to choose me as your therapist? ( ) website ( ) psychology today ( ) school

( ) friend/Co-worker ( ) corporate program ( ) social media ( ) google search ( ) other

Using the following scale, how would you rate the following?

1-poor **2-unsatisfactory** **3-satisfactory** **4-good** **5-very good**

( ) Physical health	( ) Sleep	( ) Eating habits	( ) Home life
( ) Sexual health	( ) Spiritual health	( ) Emotional/Mental health	( ) Leisure
( ) Romantic life	( ) Family life	( ) Work situation	( ) Friendships
( ) Financial situation	( ) School functioning		

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Please describe the concerns that have brought you here.

Please describe how you handle stressors and cope with the concerns you have described above.

Please identify past or present thoughts of wanting to hurt yourself or someone else.

Please identify the name of any clinician(s) you have seen in the past (psychiatrist, psychologist, counsellor, etc.),the months you saw them (e.g.,Nov 14-Feb 15), and the nature of the difficulty at the time.

Please list any diagnoses, medical or otherwise.

Please list any medications you are taking, including prescription and over the counter medications, as well as frequency and dose.

Please describe any significant current or past medical problems you have faced.

Please describe what you hope to be able to do or achieve as a result of therapy.

Please describe some of your weaknesses.

Please describe some of your strengths.

Informed Consent and Confidentiality Agreement

Welcome to 360 Wellness Spruce Grove.
We are committed to enter into an agreement of mutual respect. Please read thoroughly and initial where indicated.

1. The standard fee for 50 minute therapy sessions is $190.00.

2. Payment is taken at the reception desk before each session and receipts are issued.
We accept cash, Visa, Master Card and Debit Card, _____.

3. Fees for specialized services:
Letters are charged at minimum rate of $190.00 Emails (10min X $40.00)
Phone calls (10min X $40.00), Letters of Attendance at a min rate of $40.00,
4. Do you have an extended health benefit plan? Yes___ No____
Please note if you have extended health care insurance coverage, it is your responsibility to ensure psychological services are covered to submit your paid receipts with an insurance claim form. It's best to call your insurance Co.
Who is your insurance Co.?_____ Amount _____,

5. On your first appointment we require a signed authorization and imprint of your credit card to secure your reserved appointments. This authorized voucher will be kept in your confidential file. This card may be charged in the event of a late cancel/no show. INITIAL_____

6. As clients of 360 Wellness Spruce Grove you are entitled to:
- Confidential sessions unless:
  - there is a serious risk of harm to yourself or others
  - a disclosure of child abuse/neglect
  - the courts order disclosure or court mandated therapy
  - coordination of EPA services
  - you authorize the release of the information to a third party,
- Every client has the right: to ask about the credentials of a psychologist, to be treated with respect, to privacy & confidentiality, to access to services, to clearly understand their treatment plan, to be included in the development of goals, to understand their treatment options, to file a complaint, to decline a psychologist or change psychologists, to request access to their file.
- Confidentiality in this document means confidentiality within 360, Administrative staff book appointments & handle files. As well, the Psychologists on our team operate as a team & benefit from consulting with each other on cases. Every client has the right to understand both of these points in as much detail as needed.

7. You can choose to have appointment reminder via text or email. We require minimum 24 hour notice to cancel an appointment or 50% of the fee will be charged to your credit card. This policy applies to all clients including EAPs or other funded clients. INITIAL_____

360° WELLNESS

Informed Consent and Confidentiality Agreement

I _____acknowledge that I have been informed of the nature and purpose of the services, including the therapeutic approach as outlined above. I understand and agree that the services I have contracted are strictly therapeutic. In keeping with the therapeutic approach, no information, either written or verbal, derived as a result of the therapeutic relationship, will be appropriate for the purposes of resolving child custody and access disputes, I understand that I can, at any time, withdraw my consent without penalty, for any or all services by notifying 360 Wellness Spruce Grove.

The collection, use and disclosure of your personal information are for purposes of therapeutic assessment and treatment and case administration. This information will only be disclosed as per limits of confidentiality outlined below.

Your signature verifies Informed consent for service and agreement of confidentiality:

Name (please print)_____

Signature_____

Date_____

Therapist's Signature_____