CLARENCE Counselling CENTRE

Intake Form (Client Information)

Please fill out this information form as carefully and as thoroughly as possible. This information is confidential and will be used by your counsellor to assist you. Please use the reverse side of the last page if you wish further space.

1. First Name: _____
2. Last Name: _____

3. Gender: ☐ Male ☐ Female

Home Phone:_____
May we leave a message identifying ourselves as the Clarence Counselling Centre at this number? ☐ Yes ☐ No

4. Address: _____
_____
City: _____
Province: _____
Postal Code: _____

5. Date of Birth: ___ /____ / _____
(MM/DD/YYYY)

Work Phone: _____
May we leave a message identifying ourselves as the Clarence Counselling Centre at this number? ☐ Yes ☐ No

Cell Phone: _____
May we leave a message identifying ourselves as the Clarence Counselling Centre at this number? ☐ Yes ☐ No

6. What is your occupation?
_____

Email:
_____
_____
(Email is not considered a confidential medium of communication)

7. Marital Status:
☐Single ☐Married ☐Separated
☐Divorced ☐Widowed ☐Common Law
☐Engaged ☐Domestic Partnership

Years: married/common law ____ years
separated/divorced/widowed ____ years

8. Partner's Name: First: _____ Last _____ Date of Birth _____
9. Partner's Gender: ☐Male ☐Female **Partner's Occupation:** _____
10. Partner's Address: (If different from yours):
_____

11. Children or Dependents

Name of child	Gender	Age	Living with You?

12. How did you find out about the Clarence Counselling Centre? Who referred you?

☐ Previous Client
☐ Word of Mouth
☐ Colleague/Friend
☐ Court
☐ Employer
☐ Doctor (Please Provide Name) _____
☐ Lawyer
☐ Other
☐ Probation Official
☐ School
☐ Self (includes Phonebook & internet)
☐ Family

13. When are you available for counselling sessions?

☐ Days ☐ Evenings ☐ Saturday ☐ Certain days: _____

14. Please describe the issues(s) for which you are seeking counselling. State your main concerns:

_____
_____
_____
_____
_____
_____
_____

15. How long has the issue been occurring?

_____
_____

16. Would you like anyone else involved in the counselling with you? (Family members, friends, etc.)

_____
_____

17. How would you rate your current physical health?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good ☐ Excellent

18. Are you currently in treatment for any medical problems, including taking medication of any type? Seeing a health professional? Please explain:

_____
_____
_____

19. Are you currently experiencing overwhelming sadness, grief, or depression? If yes, for how long?

_____
_____
_____

20. Please list any difficulties with your eating patterns/ sleeping patterns /chronic pain?

_____
_____
_____

21. Are you currently experiencing anxiety, panic attacks or have any phobias?
☐ Yes ☐ No

_____
_____

22. Is there any concern about suicide? Please explain:

_____
_____

How concerned are you about suicide on a scale of 1-10 (10 being the worst)

_____

Do you have someone you can talk to about it at home or in your community?

_____

If you need to talk to someone before a counsellor can meet with you, please call the Distress Crises Line 1-780-963-6151 or Provincial Help Line 1-800-779-5057 they are a 24-hour crises line and are always available to talk. If you need urgent help, go to an emergency room where you can get help if you feel you might hurt yourself.

23. What significant life changes or stressful events have you experienced recently?

_____

_____

_____

_____

24. Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No
If yes, describe your faith.

_____

_____

25. What are your feelings about God right now?

_____

_____

_____

26. Have you previously received any type of mental health services Psychotherapy? Psychiatric services? Counselling? ☐ Yes ☐ No

27. Where did you go?

_____

What was it concerning?

_____

_____

_____

28. In this question, please identify if there is a family history of any of the following. If "yes," please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc)

	Please Choose	List Family Member
Alcohol/Substance Abuse	☐ Yes ☐ No	_____
Anxiety	☐ Yes ☐ No	_____
Depression	☐ Yes ☐ No	_____
Domestic Violence	☐ Yes ☐ No	_____
Eating Disorders	☐ Yes ☐ No	_____
Obesity	☐ Yes ☐ No	_____
Obsessive Compulsiveness	☐ Yes ☐ No	_____
Schizophrenia	☐ Yes ☐ No	_____
Suicide Attempts	☐ Yes ☐ No	_____

29. Are your parents still living? Mother _____ Father _____
Describe your parents' marriage: (Choose one)
☐ very happy ☐ happy ☐ average ☐ unhappy ☐ very unhappy
Describe your life as a child: (Choose one)
☐ very happy ☐ happy ☐ average ☐ unhappy ☐ very unhappy
Describe your life as a teenager: (Choose one)
☐ very happy ☐ happy ☐ average ☐ unhappy ☐ very unhappy

30. Have you been to the Clarence Counselling Centre before? ☐ Yes ☐ No
When: _____
What was it concerning?
_____
_____
_____

31. Is there anything else that you want your counsellor to know before you come in for an appointment?
_____
_____

32. What would you like to accomplish as a result of your time(s) in therapy? Your goals?
_____
_____
_____
_____

Please complete the following information to confirm that the proper fee has been set:
Employer _____ Gross Salary _____
Employer of spouse/partner _____ Gross Salary _____

33. We can provide in-person sessions for the most part, but are you open to zoom/FaceTime sessions? (This negates travel time and childcare costs)
☐ Yes ☐ No

34. Do you wish couple counselling with both Simon and Ruth? ☐ Yes ☐ No
Or. Simon only. ☐ Yes ☐ No
Or Ruth only ☐ Yes ☐ No

PAYMENT OPTIONS

1. E-transfer (preferred)
Email to: clarencecounsellingcentre@gmail.com

2. Credit Card Payment: Visa/MasterCard
Number (16 digits) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Expiry Date ☐☐ / ☐☐ CVV (3 digits) ☐☐☐

Signature_____

I understand that any outstanding amount on my account will be processed after 30 days on this credit card.

Your fees may be reimbursed by your private insurance company. Some companies cover, while others require a licensed psychologist designation.

Some companies cover our fees under a Health Spending Account.

Explore your options with your insurance provider.

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed or emailed to all clients who do not show up for, or cancel an appointment without a justifiable cause.

Thank you for your consideration regarding this important matter.

_____
Clients Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or a vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature (Client's Parent/Guardian if under 18)

Today's Date: _____

NOTE: Rev. Simon and Rev. Ruth Clarence are not registered psychologists or registered psychiatrists. They offer no medical or legal advice.

☐ **I understand and acknowledge** that they are pastoral counsellors only and are requesting their services on that criteria.

It is important to us to know that you have read and understand the above information. If this is the case, please sign below.

If you have any concerns you may wish to discuss them with you counsellor before you sign.

In an effort to keep information confidential and to facilitate communication for the most effective treatment, Clarence Counselling Centre will keep one file of your records.

I have read and understood the above information. I agree to abide by its terms.

Name _____

Signature_____

Date _____