DATE OF INTAKE: _____/_____/_____

New Harmony Counselling Services

INTAKE FORM and CLIENT CONSENT

Welcome! And thank you for your willingness to engage in this process of growth and development.

Office Policies and General Information:

Email: pamela@newharmony.ca
Telephone: (613) 735-1112

Messages: If I am unavailable to take your call, please leave your name, telephone number and the best time to call you back on the voice messaging machine and I will return your call as soon as possible.

Your session time has been exclusively reserved for you. Unless otherwise negotiated ahead of time, appointments are an hour in length, with each session running approximately 50 minutes. Cancellation of an appointment requires 24 hours' notice (by email or phone). Without such notice we will consider that you have used the time and you will be billed for it. My software program is capable of giving you notice by text or email to remind you of your appointment.

Payment is due in full at the conclusion of each session. Payment may be made by cash, cheque, or e-transfer. Your therapy may be covered by your employee benefits package or insurance. Check with your insurer **before** you begin therapy, as some insurers will only reimburse for therapy receive from a psychologist or social worker. I am a registered psychotherapist and **not** a psychologist.

Confidentiality: Confidentiality is **very important** in the counselling relationship, and I promise to hold all our private conversations in strict confidence. During the initial session, I collect contact, personal, and health information from you. I will not share your information in any way without your express permission. Hard copies of that information are stored in a private, locked filing cabinet. Client case records and progress notes are stored electronically on a password-protected, encrypted computer database system (*OWL Practice*). I will not disclose anything that is discussed within a session with anyone other than my clinical advisory group—other psychotherapist colleagues who are bound by the same rules of confidentiality as I am. No information will be released to a third party without a signed release from all parties involved, except where required by federal or provincial laws requiring the reporting of threats, violence, bodily harm, child abuse and neglect, or when the release of information is ordered by a legally recognized court.

Circle of Care: You may choose to include your family doctor, a parent, your partner, your emergency contact, or other designated persons in your "Circle of Care", and those people may then be aware that you are in therapy, and that you are attending sessions. However, no information about your therapy will be released by me without a signed release form.

By signing this document, you indicate that you understand the limits of confidentiality, my professional and legal duty to report potential harm and abuse, and you agree to live with the consequences of such reporting.

Please provide the following information and answer the questions below.
Note: Information you provide here is protected as confidential information.

1. CONTACT INFORMATION

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ M □ F □ T
(Year) (Month) (Day)

Cell/Mobile Phone: ( ) _____ May we leave a message? □ Yes □ No

Other Phone: ( ) _____ May we leave a message? □ Yes □ No
(work, home)

E-mail: _____ May we email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Address:

_____
(Number and Street **OR** Postal Box)

_____
(Apartment Number)

_____
(City) (Province) (Postal Code)

2. EMERGENCY CONTACT PERSON

Name: _____
(Last) (First) (Middle Initial)

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

Relationship to client: _____

3. FAMILY INFORMATION

Are you currently in a romantic relationship? □ Yes □ No

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current romantic relationship?

_____

In the last year, have you experienced any significant life changes or stressors in your family life? If yes, please explain:

_____

_____

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes**	**No**	**Family member**
Depression	Yes	No	
Bipolar disorder	Yes	No	
Anxiety disorder	Yes	No	
Panic attacks	Yes	No	
Schizophrenia	Yes	No	
Alcohol/substance abuse	Yes	No	
Eating disorders	Yes	No	
Learning disabilities	Yes	No	
Trauma history	Yes	No	
Suicide attempts	Yes	No	
Chronic illness	Yes	No	

4. GENERAL HEALTH INFORMATION

Family Doctor: _____ Telephone: _____

Doctor's Location: _____
(City) (Province)

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.)

_____

_____

Are you currently taking any prescription medication? □ Yes □ No

_____

_____

Describe your level of exercise or activity in an average week.

_____

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, individual or group counselling)? □ No

□ Yes, previous therapist/practitioner/counsellor:

Name: _____

Therapist/practitioner/counsellor's location:

_____

What was the concern for which you were receiving counselling previously?

_____

Are you still seeing this practitioner? □ Yes □ No

Have you ever been prescribed a psychiatric medication? □ Yes □ No

_____

_____

Have you ever experienced any of the following?

Extreme depressed mood	Yes	No	
Dramatic mood swings	Yes	No	
Rapid speech	Yes	No	
Extreme anxiety	Yes	No	
Panic attacks	Yes	No	
Phobias	Yes	No	
Sleep disturbances	Yes	No	
Hallucinations	Yes	No	
Unexplained losses of time	Yes	No	
Unexplained memory lapses	Yes	No	
Alcohol/substance abuse	Yes	No	
Frequent body complaints	Yes	No	
Eating disorder	Yes	No	
Body image problems	Yes	No	
Repetitive thoughts (e.g. obsessions)	Yes	No	
Repetitive behaviors (e.g. frequent checking, hand washing	Yes	No	
Homicidal thoughts	Yes	No	
Suicidal attempts	Yes	No	If yes, when?

Would you like to have someone listed in your circle of care? □ Yes □ No
(This could be a doctor, parent, partner, emergency contact, other…)

_____

_____

5. OCCUPATIONAL INFORMATION

Are you currently employed? □ Yes □ No

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any _____

_____

_____

6. RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? □ Yes □ No

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? □ Yes □ No

7. EXPECTATIONS

What are your goals for therapy? What do you hope to get from counselling at **New Harmony**?

_____

_____

_____

What are your strengths?

_____

_____

Have you learned any coping strategies that work for you?

_____

_____

Please list any other information you think is important for your counsellor to know about you.

_____

_____

How did you find out about **New Harmony**?

_____

Will you be requiring receipts for reimbursement from an insurance company or employee benefits package? □ Yes □ No

8. CONSENT FOR THERAPY

I understand the limits of confidentiality, I understand my counsellor's duty to report potential harm and abuse, and I agree to live with the consequences of such reporting.

_____ _____
Client Signature (if client is age 12 or over) *** Today's Date

_____ _____
Parent Signature (if client is under age 18) *** Today's Date

_____ _____
Therapist signature Today's Date

*** If the client is under age 18, a parent or guardian **must complete** a separate form "When the Client is a Minor".

Please talk to me about any concerns that you have about our work or relationship. Comments, concerns and/or requests are most welcome.

Pamela D. Harrington, M.A., R.P., R.M.F.T.
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