Carissa Jackson (BSW) (RSW)
Counselling Services
carissa.l.jackson@gmail.com
289.838.5433

1. Personal Information

Please fill out the following details.

- Full Name: _____
- Preferred Name (if different): _____
- Date of Birth: _____
- Gender (Optional): _____
- Phone Number: _____
- Email Address: _____
- **Address:**
- Street: _____
- City: _____
- State/Province: _____
- Zip Code: _____
- **Emergency Contact:**
  Name: _____
- Relationship: _____
- Phone Number: _____

2. Referral Information

How did you hear about our services? (Please check all that apply)

- Referral from a friend/family member
- Primary care physician
- Online search (Google, Yelp, etc.)
- Insurance provider
- Other (please specify): _____

3.. Reason for Seeking Counselling

Please take some time to share what brought you to counselling. This information helps us understand your needs and goals.

- **Primary concern(s) or issue(s) you'd like to address:**

- **What are your goals for therapy?**

4. Mental Health History

Please check any mental health concerns that apply to you or have in the past:

- Anxiety
- Depression
- Stress
- Trauma/PTSD
- Eating disorders
- Obsessive-compulsive disorder (OCD)
- Bipolar disorder
- Self-harm or suicidal thoughts
- Substance use/addiction
- Other (please specify): _____

Have you received any previous mental health counselling or therapy?

- Yes
- No

  If yes, please provide details:

- Therapist's Name/Practice: _____
- Dates of Service: _____
- Reason for seeking therapy: _____

5. Current Medications

Please list any current medications you are taking (including dosages and reason for use).

- Medication Name: _____
- Dosage: _____
- Reason for use: _____

6. Medical History

Please check any medical conditions that apply to you or have in the past.

- Heart disease
- Diabetes
- High blood pressure
- Seizures
- Chronic pain
- Sleep disorders
- Other (please specify): _____
-

Are you currently under the care of a physician or other medical professional?

- Yes
- No

If yes, please provide details:

- Physician's Name: _____
-
- Specialty: _____
-
- Phone Number: _____

7. Family History

Is there a history of mental health issues in your family? (Please check all that apply)

- Anxiety
- Depression

- Substance abuse
- Bipolar disorder
- Suicide
- Other (please specify): _____

8. Additional Information

Please feel free to provide any other information you think might be helpful in your therapy.

_____
_____
_____
_____
_____

10. Informed Consent and Confidentiality Agreement

Please read and sign the following statement. This ensures that you understand your rights, the limits of confidentiality, and the process of therapy.

In the course of my work, I record brief information about you and your treatment for the purpose of providing continuity and quality care. Records will be stored securely for seven years and then destroyed.

Confidentiality: Confidentiality is respected at all times. No information will be disclosed without your explicit consent. Rare exceptions include the following legal and ethical obligations:

*Intent to seriously harm oneself or others

*A court order to release a file

*Knowledge or suspicion of child abuse or neglect

*A registered professional who has abused a past client/patient

*A need to identify myself legally because of a complaint

Emergencies: I DO NOT provide emergency services. In the case of an emergency call 911, your family physician or go to the nearest hospital emergency department.

Use of Technology: Clients will use text msg, email or video chat to communicate with me. Some session will be done virtually. It is important to note that these methods of communication come with additional privacy risks.

Consent for Treatment: By signing below, you consent to participate in counselling and understand and agree with the confidentiality agreement. You have the right to discontinue services at any time. You understand that therapy is a collaborative process and results may take time.

- **Client Signature: _____**
- **Date: _____**

11. Payment & Scheduling Policies

Payment:

- Payment is due at the time of service unless other arrangements are made.
- Acceptable payment methods: [Cash or e-transfer.]

Cancellation Policy:

- If you need to cancel or reschedule your appointment, please do so at least 24 hours in advance. A late cancellation or missed appointment will result in paying the full $160 fee.

- **Client Signature (acknowledging policies):**

- _____Date: _____

Parental Consent for Treatment Form
For Minors (Under Age 18)

Thank you for trusting Carissa Jackson with your child's mental health care. This form is required for any client under the age of 18 and is designed to provide important information about our treatment process and the rights and responsibilities of both the parent/guardian and the minor.

1. Parent/Guardian Information

- **Parent/Guardian Name(s): _____**

- **Relationship to Child: _____**

- **Phone Number(s): _____**

- **Email Address: _____**
- **Address (if different from child's): _____**

2. Consent for Treatment

As the legal guardian(s) of the minor named above, I/we give permission for Carissa Jackson to provide counselling and therapeutic services for my/our child. I/we understand that therapy may include individual, family, and/or group counselling as appropriate and in the best interest of my/our child.

I/we acknowledge that my/our child's participation in counselling is voluntary and may be discontinued at any time by the parent/guardian or the minor.

3. Confidentiality and Limits of Confidentiality

I/we understand that all information shared during therapy sessions is confidential and will not be shared with others without the minor's or the guardian's consent. However, I/we understand that there are legal exceptions to confidentiality, including but not limited to:

- If there is a risk of harm to my/our child or others.
- If there are reports of abuse or neglect (physical, emotional, or sexual).
- If the minor is at risk of self-harm or suicidal ideation.
- If a court of law requires the disclosure of information.
-

I/we understand that the counsellor may discuss my/our child's progress with me/us as needed, and I/we agree to participate in treatment planning and discussions when necessary.

4. Treatment Goals and Parent/Guardian Involvement

I/we understand that therapy will be a collaborative process, and I/we will be encouraged to provide input regarding the treatment goals and progress. However, the minor may request sessions in which parental involvement is not required, and I/we acknowledge the importance of providing a safe, private space for the minor's self-expression.

5. Consent for Emergency Care

In case of an emergency (e.g., if the counsellor believes the minor is at risk of harm to themselves or others), I/we understand that the counsellor may need to take immediate action to ensure safety, which may include notifying emergency contacts or medical personnel.

- **Emergency Contact (if different from Parent/Guardian):**
  Name: _____
  Phone Number: _____

6. Understanding of Rights

I/we understand that my/our child has the right to:

- Ask questions and seek clarification about the treatment process.
- Have a say in their treatment plan and goals.
- Discontinue services at any time, with notice to the counsellor.
- Confidentiality, with the exceptions listed in this form.
-

By signing below, I/we consent to the treatment of my/our minor child as outlined in this form and am in agreement/compliance with all the above information.

Parent/Guardian Signature(s):
_____

Date: _____

Counsellor's Name and Signature: _____

Date: _____

This consent form ensures transparency between the counsellor, the minor client, and the parent or guardian, fostering a supportive, informed environment for the child's treatment. Be sure to adjust the form to fit your practice, and it's always a good idea to consult legal professionals for compliance with local regulations or specific clinical circumstances.