

Date file opened: _____

Chart #: _____

INTAKE FORM

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: _____



Blake Psychology

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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)

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 6 7 8 9 10 (Incapacitating)

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



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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 check-up 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 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 or a check addressed to Blake Psychology. **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) you are under 14 years of age, and your parents/legal guardians want access to your file, (2) risk of imminent danger, such as suicide, death, risk of 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 your name will not be released without your 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

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