



Blake Psychology: Pointe-Claire
6500 Trans-Canada Hwy, Suite 400
Pointe-Claire, QC H9R 0A5
www.blakepsychology.com
T: 514-319-1744 F: 1-877-417-4420

Blake Psychology: Montreal
2001 University street, Suite 1700
Montreal, QC H3A 2A6
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Date file opened: _____

Chart #: _____

CHILD THERAPY INTAKE FORM

Please complete on behalf of your child

Name of person completing this form: _____

Your relation to the child: _____

Phone: _____ Email: _____

Name of other parent/legal guardian: _____

Phone: _____ Email: _____

Child's first name: _____ **Last name:** _____

Age: _____ Birth day: _____ Month: _____ Year: _____

Ethnicity: _____ Religion: _____ Sex/gender: _____

Home address: _____

Who does your child live with? _____

ACADEMIC INFORMATION:

Name of child's school: _____ Grade/year: _____

Program: _____ Typical grades: _____

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: _____



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THE REASONS FOR YOUR CHILD'S VISIT:

How intense is your child's emotional distress?

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Please describe: _____

Overall, how much do the problems affect your child's ability to perform 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)

Please describe: _____

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



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PSYCHIATRIC AND MEDICAL HISTORY

Please list any **psychiatric or "mental"** problems your child has been diagnosed with:

Please list any **medical or "physical"** problems that your child has been diagnosed with:

Please list any **medications your child currently takes**, and what they are taken for:

Name of **Family doctor:** _____ Phone: _____

Last check-up was during the month of: _____ Year: _____

Results: _____

Name of **Psychiatrist:** _____ Phone: _____

Last visit was during the month of: _____ Year: _____

Results: _____



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MENTAL HEALTH TREATMENT HISTORY

Has your child ever been hospitalized for psychological or psychiatric reasons? No Yes

If yes, please describe when and where, and for which reasons.

Please tell us about any other mental health professionals your child has 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 child's **current habits** in each of the following areas:

Smoking: _____

Drinking: _____

Drug use: _____

TV use: _____

Internet use: _____

Video game use: _____

Caffeine intake: _____

Exercise: _____

Eating: _____

Sleeping: _____

Fun and relaxation: _____

Chores and responsibilities: _____



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RELATIONSHIPS

Please describe your child’s 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 your child has been experiencing:

	No	Yes	If yes, please describe
A recent move or change in school?			
Abuse or neglect?			
Bullied or ignored by peers?			
Academic difficulties?			
Weight control issues?			
Sexual orientation concerns?			
Self-injury?			
Death or illness of a loved one or pet?			
Family conflict?			
Separation or Divorce?			
Other?			



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What are your child's positive qualities and skills? What do you like about your child? What qualities have helped your child to succeed at overcoming difficulties in the past?

Please tell us about your child's interests (sports, hobbies, talents, etc.)

Does your child agree that the problem that she or he is seeking help for is problematic?

What are some goals for your child's therapy? What would you like them to achieve by attending therapy?

What concerns do you have about your child attending therapy or working on these problems?

Is there anything else that you would like to mention?



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CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES: Clinic Copy

This consent form explains the nature of the psychological services that your child is 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 child's difficulties and readiness for change, (iii) Termination: Approximately 1-2 sessions, involves developing a "toolbox" of strategies that may be used to help your child maintain 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 the current difficulties may have developed and are maintained within the various contexts of your child's life. The results of this assessment may 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 your child reach the 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 child's 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, debit, or credit card. **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 can be released to a third party without your prior written consent, or verbal consent in the case of an emergency. Exceptions include: (1) when children are under 14 years of age, and their parents/legal guardians want access to the file, (2) risk of imminent danger, such as suicide, death, risk of a child 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 names will not be released without consent.

Mutual rights and responsibilities: The relationship must remain limited to a respectful therapeutic framework. You/your child may refuse any therapeutic suggestions offered, 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 the file can be closed and/or a referral can be referred to another resource. If you stop treatment without an explanation, the 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 have my child receive psychological services.

Name of child client: _____ Today's date: _____

Name of parent/guardian: _____ Signature: _____

Name of parent/guardian: _____ Signature: _____



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Name of parent/guardian: _____ Signature: _____

Name of parent/guardian: _____ Signature: _____