Blake Psychology

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
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Date file opened: _____

COUPLES THERAPY INTAKE FORM

Please complete this form individually

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: _____

EMPLOYMENT INFORMAITON:

☐ 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: _____

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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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 visit was during the month of: _____ Year: _____

Results: _____

_____

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MENTAL HEALTH TREATMENT HISTORY

Have you ever been **hospitalized for psychological or psychiatric reasons?** ☐ Yes ☐ No

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

_____

_____

_____

Have you **received prior couple counselling**? And, if yes, for what problems? ☐ Yes ☐ No

If yes, when:_____ Where:_____

By whom:_____ Length of treatment:_____

Problems treated:_____

_____

Was the outcome successful? □ Very □ Somewhat □ No change □ Got worse

Have you ever been in **individual counselling before?** ☐ Yes ☐ No

If yes, give a brief summary of concerns you addressed_____

_____

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:

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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?			

RELATIONSHIP THAT YOU ARE SEEKING HELP FOR

For how long have you been married, cohabiting, separated, or divorced: _____

Please rate your **current level of relationship satisfaction** by circling the number that corresponds with your current feelings about the relationship:

(extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

What are your **expectations for counselling:** _____

_____

_____

_____

_____

_____

_____

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What are your **treatment objectives** (check all that apply):

- □ Improve communication
- □ Problem solving
- □ More quality time together
- □ More respect/understanding
- □ More social contacts
- □ Conflict resolution
- □ More intimacy (emotional)
- □ Resolve individual issues
- □ Power and control issues
- □ More sharing of the chores
- □ Parenting skills
- □ More intimacy (sexual)
- □ More autonomy
- □ More hobbies
- □ Help for children's behaviour
- □ Other (specify):

What have you already tried to address these difficulties?_____

_____

_____

Whose idea was it to come to therapy? _____

Was there a prompting event that led someone to make this call? **(Why seek help now?)** _____

_____

_____

_____

What are your **biggest strengths** as a couple?_____

_____

_____

_____

Please make at least three suggestions as to something ***you*** **could personally do to improve** the relationship regardless of what your partner does: _____

_____

_____

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Do either you or your partner **drink alcohol** or **take drugs** to intoxication? ◻ Yes ◻ No

If yes for either, who, how often and what drug/alcohol? _____

_____

_____

_____

Have either you or your partner **physically restrained, harmed, or injured** the other person?

E.g., pushed, shoved, grabbed, or slapped, etc. □ Yes □ No

If yes for either partner, who, how often and what happened? _____

_____

_____

_____

Has either of you **threatened to separate/divorce** as a result of the current relationship problems?

◻ Yes ◻ No If yes, who? ____Me ___Partner ___Both of us

If married, have either of you **consulted with a lawyer about divorce?**

◻ Yes ◻ No If yes, who? ____Me ___Partner ___Both of us

Do you perceive that either you or your partner has **withdrawn from the relationship?**

◻ Yes ◻ No If yes, who? ____Me ___Partner ___Both of us

Have you or your partner **ever emotionally or physically cheated on each other?**

◻ Yes ◻ No □ Unsure If yes, who? ____Me ___Partner ___Both of us

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How satisfied are you with the **frequency of your sexual activities?** (circle one)

(extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

How satisfied are you with the **quality of your sexual activities?** (circle one)

(extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

What is your current level of **stress (overall)?** (circle one)

(No stress) 1 2 3 4 5 6 7 8 9 10 (extremely stressed)

What is your current level of **stress in the relationship?** (circle one)

(No stress) 1 2 3 4 5 6 7 8 9 10 (extremely stressed)

Name the **top three concerns** that you have in your relationship with your partner ("1" being the most problematic):

1. _____
2. _____
3. _____

How important is it to you to improve the quality of your relationship?

(not important) 1 2 3 4 5 6 7 8 9 10 (extremely important)

How willing are you to make "working on this relationship" a priority in your life?

(not willing) 1 2 3 4 5 6 7 8 9 10 (extremely willing)

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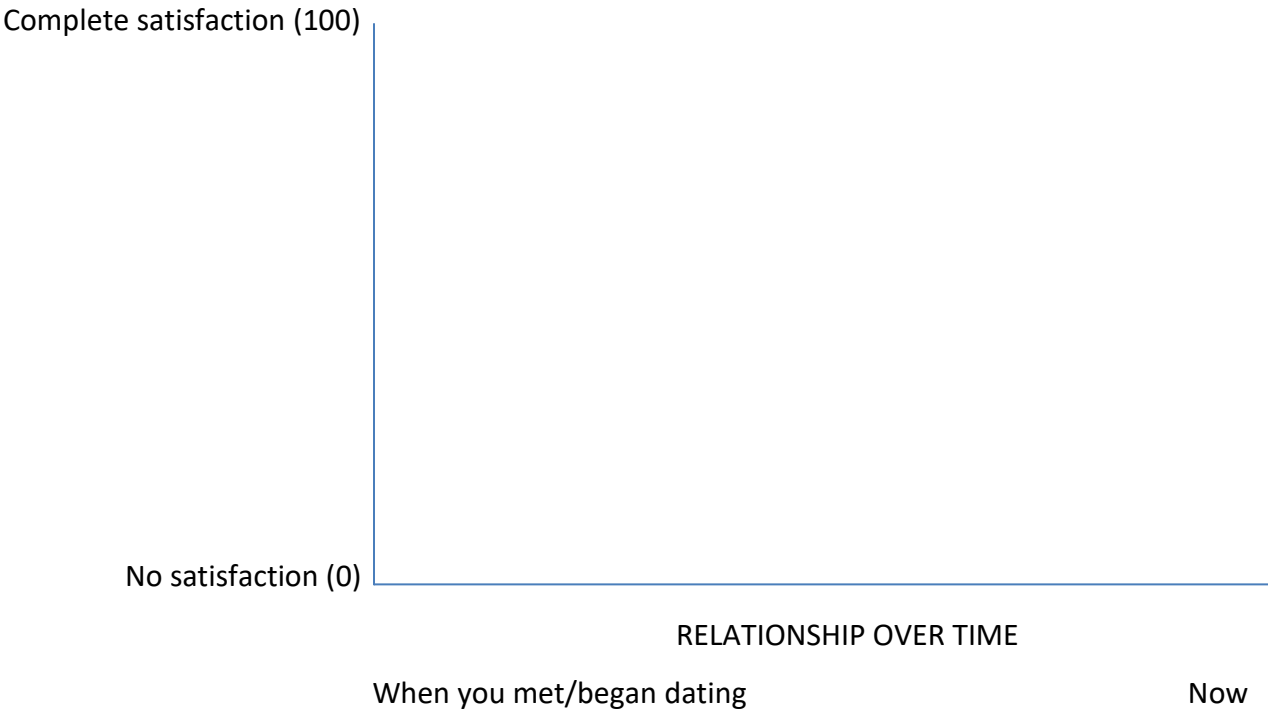
Lastly, please **draw a graph indicating your level of relationship satisfaction** beginning with when you met your partner. Mark pivotal/significant events in your relationship (e.g., birth of your child, one of you cheated, one of you moved out, etc.).



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 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, debit, or credit card. **FOURTY-EIGHT (48) full hours' notice *is required to* CANCEL OR RESECHEDULE *an appointment to avoid being billed an administrative fee for the full cost 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 may be destroyed 5 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) 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, (3) suspected or known abuse or neglect of a child or older adult, (4) unsafe operation of a motor vehicle, (5) requests ordered by a court of law or the Order of Psychologists of Quebec, (6) access is required by personnel (e.g., administrative staff) to carry out their professional duties, or (7) limitations inherent in technology such as email, phone, or Skype. 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 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: _____

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CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES: *Client Copy*

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