**Blake Psychology Montréal**
2001 Robert-Bourassa, Suite 1700
Montreal, QC H3A 2A6

Tel: 514-319-1744

**Blake Psychology Pointe-Claire**
6500 Trans-Canada Hwy, Suite 400
Pointe-Claire, QC H9R 0A5

http://www.blakepsychology.com

Date file opened: _____

# RETURNING CLIENT INTAKE FORM

***To be completed by clients who are re-opening their file***

First name: _____ Last name: _____

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

Home address with postal code: _____

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: _____

**The reasons for your visit:**

_____

_____

_____

**Any important changes since your last visit (e.g., job, relationship, medications, etc.):**

_____

_____

_____

_____

_____

**How intense is your emotional distress from 1 (mild) to 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 (Incapacitating)

Please describe: _____

_____

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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: _____

***For clients ages 13 and younger:**

Name of parent/guardian: _____ Signature: _____ Date: _____

Name of parent/guardian: _____ Signature: _____ Date: _____

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## CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES: *Client's Copy*

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**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.

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**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: _____