Intake Form – Counselling Clients (Child/Youth)

Name of Child/Youth: ______________________________________ Date of Birth: _______________

Home Address: ____

Cell phone of Youth: ___________________ (if applicable)

Parent/Guardian/Emergency Contact information:

Name of Guardian(s):____

Emergency Contact: ____

Guardian's Home Phone: ______________________________May we leave a message? [ ] Yes [ ] No

Guardian's Work Phone: _______________________________ May we leave a message? [ ] Yes [ ] No

Guardian's Mobile Phone: ______________________________ May we leave a message? [ ] Yes [ ] No

Guardian's Email: _________________________________ (May be used for reminders of apt times)

Address: ____

Family Physician ____ Phone: ___________________________

Extended Health: Yes□ No □ Provider: __________________ (Please ensure they cover a Registered Social Worker)

Are you or your child involved in any processes/claims with □ ICBC □WCB □ Criminal Injuries Compensation? □ Other ____________________________________

Any prescription medication? □ Yes □ No Duration: _____________________

Medication: __________________________________ Dose: _________________________________

Medical Condition(s):
____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates:
____

____

Supplements/Vitamins □ Yes □ No or Remedies □ Yes □ No? Describe: ________________________

Are you currently receiving or have you received any of the following types of therapy? □ Massage □ Physiotherapy □ Naturopath □ Chiropractor □ Other counselling services □ Psychology □ Psychiatry □ Physician □ Other____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes Previous therapist/practitioner type: ____

Tell me a bit about you/your child:

School/Student:____ Grade:____________

College/University:____ Year: _______________

Employment: ____

Hobbies/Interests:
____

Please tell me briefly why you are coming to counselling. What are your goals (or goals for your child) (You may include, how long you have been experiencing your challenges, what are your current stressors, behaviours or concerns)

____

____

____

____

What significant life changes or stressful events have you experienced recently?
____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

____

____

How many times per week do you generally exercise? ___________

What types of exercise to you participate in ______________________________________

Please list any difficulties you experience with your appetite or eating patterns

____

How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes (Please circle)

If yes, for approximately how long? _________________________

Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes (Please circle)

If yes, when did you begin experiencing this? ____________________________

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe ____________________________

Do you/your child drink alcohol more than once a week? □ No □ Yes

How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently

□ Never

Are you currently in a romantic relationship? □ No □ Yes □ N/A

If yes, for how long? _______ On a scale of 1-10, how would you rate your relationship? ________

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

In order to help you and I work together as best as possible, is there anything else that you would like to add or share that has not been asked on this form that you feel could be relevant for me to know? (I.e. past events or situations that are of significance to you that you are comfortable putting in writing?)

____

____

____

FOLLOW UP:

If I have not heard from you in 4-6 weeks would you like a follow up contact? □Yes □No

If yes, would you like to be contacted by phone or email? Phone Email (Circle One)

Email address ______________________________ OR Phone ________________________

If phone – may I leave a brief message? □Yes □No

Signed __________________________________ Date __________________________

Optional:

NEWSLETTER: Would you like your email added to the Balance Clinic newsletter mailing list? □Yes □No

How did you hear about counselling? □ Naturopath □ Doctor □Physical Therapist □ Friend □ Family □ Website □ Facebook □ Other

Referred by: ______________________________________

Cancellation/ No Show Policy

Missed Appointments

When you book an appointment with us, that time is set aside for you - and ONLY you. Please understand that missed appointments prevent us from working with other clients.

Our Cancellation Policy

You may sometimes need to cancel your appointment with us, so we have tried to make our cancellation policy as simple as possible.

If you provide us with:

- **At least 24 hours notice** – there is no charge for cancelling your appointment
- **Less than 24 hours notice** – there will be a $60 charge for the missed appointment
- **Less than 3 hours notice OR you simply don't show up** – we consider this a "no-show" and you are expected to pay 100% of the fee for the missed appointment
- If you do not reach us, please leave a message on our voice-mail system. Note that with Monday appointments we will need to hear from you the Friday before as the receptionists do not check voicemail on the weekend and it won't be heard until Monday at 9 am.

Note: We recognize that there are circumstances that are out of your control (sudden illness, family emergencies, etc.) and so your healthcare provider may make an exception to the above policies on those rare occasions. You will need to speak to your service provider directly for an exception.

I understand the above policy and agree to pay for missed appointments and for cancellations with less than 24 hours notice.

Signature: ___________________________ Date: _________________

____ Date: __________________
Signature of parent or guardian if client is under 19 years of age

Confidentiality:

The information that we discuss and that is documented in the chart is confidential; it would be shared only with your written consent. (A form with your signature would need to be completed).

Limits of Confidentiality:

It is important that you are aware that I would be required by law to release information/report when:

- a client poses a risk of harm to themselves or others
- in cases of abuse or neglect to children (*Child and Family Community Services Act*)
- in cases of abuse or neglect to vulnerable adults or the elderly (*Adult Guardianship Act*)
- if I receive a court order or subpoena, I may be required to release some information
  In such a case, I will consult with other professionals and the College of Social Work and its practice standards. I would release to only what is necessary by law. (*Freedom of Information and Protection of Privacy Act, BC College of Social Work Practice Standards*)

Clinical Supervision Consultations - In review of my practice, interventions and effectiveness, I seek clinical consultation with an approved clinical supervisor who is also bound by confidentiality laws. In the event of a clinical consultation, no names or identifying information of any clients is shared.

By signing below, I agree that I understand confidentiality and the limits of confidentiality as outlined above.

Signed,

______________________________ ______________________
Client Date

______________________________ ______________________
Guardian (as required) Date

Consent for Counselling Services – Children and Youth

I _________________________, (parent or legal guardian's name) warrant that I have the authority to consent for my children to participate in counselling offered by Niki Knight, MSW RSW. I hereby give consent for my child to participate in counselling offered.

I understand and agree that I am responsible for my child's safety and transportation to and from counselling appointments.

I understand that my child will have the opportunity to share his/her/their feelings, expectations and attitudes about our life circumstances. Should I be included in on the counselling, my involvement will focus on the ways of helping the child to adjust more successfully to these circumstances, and to contribute to general family wellness.

I understand and agree that all information, communications, observations and opinions derived from counselling shall be considered private and confidential within the limitations of ethical practice and applicable Provincial legislation. (As outlined in the Confidentiality Sheet). I also acknowledge that Niki Knight will maintain my confidentiality of information and documentation the extent allowed by the law.

I agree that neither myself nor anyone representing me shall call on Niki Knight or other employees of Balance Natural Health Clinic during or at any time after it to provide either written or oral testimony at any examination trial, or application in any court where the marriage, the custody of or the access to the child are in issue or are related to the issues or dispute between me and any other person. Niki Knight does not provide specialized custody/access assessments.

I understand that if I wish I may obtain legal advice prior to signing this consent. I have signed to indicated that I have read, understood and agree with the above.

*Name of Parent/Legal Guardian:____

**Name of Child:____

Address:____

Signed:______________________________ Witness:__________________________

Date:_________________________________ Date:_____________________________

***Consent is required from both parents in joint guardianship. 2 forms will be signed.**

****Separate forms are required for each child.**