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Date file opened: _____

Chart #: _____

FAMILY THERAPY INTAKE FORM

Fill out Individually (for clients ages 14+)

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 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: _____

HOW YOU FOUND THIS CLINIC:

Word of mouth I'm a former client Social Media From our website

From a Doctor, Please Name the Doctor _____

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:

Three horizontal lines for writing psychiatric or mental problems.

Please list any medical or physical problems that you have been diagnosed with:

Three horizontal lines for writing medical or physical problems.

Please list any medications you currently take, and what you take them for:

Three horizontal lines for writing medications and their purposes.

Name of Family doctor: Phone:

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

Results: Two horizontal lines for writing results.

Name of Psychiatrist: Phone:

Last visit was during the month of: Year:

Results: Two horizontal lines for writing 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.

Have you **received prior family 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: _____

STRESSFUL LIFE EVENTS

Please describe any **current 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?			

QUESTIONS ABOUT YOUR FAMILY

How close you feel to your family members: (distant) 1 2 3 4 5 (close)

How well you get along with your family members: (poorly) 1 2 3 4 5 (great)

What are the **family and/or household rules**? _____

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

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Improve communication | <input type="checkbox"/> Conflict resolution | <input type="checkbox"/> Parenting skills |
| <input type="checkbox"/> Problem solving | <input type="checkbox"/> More emotional safety | <input type="checkbox"/> More physical safety |
| <input type="checkbox"/> More quality time together | <input type="checkbox"/> Resolve individual issues | <input type="checkbox"/> More autonomy |
| <input type="checkbox"/> More respect/understanding | <input type="checkbox"/> Power and control issues | <input type="checkbox"/> More hobbies |
| <input type="checkbox"/> Less harsh discipline | <input type="checkbox"/> More sharing of the chores | <input type="checkbox"/> Help for children's behaviour |
| <input type="checkbox"/> 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 family? _____

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



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Does anyone in your family **drink alcohol** or **take drugs** to intoxication? Yes No

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

Has anyone in your family **physically restrained, harmed, or injured** the other person?

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

If yes, who, how often and what happened? _____

Is your family **at risk for splitting up?** Yes No Unsure

If yes or unsure, please describe _____

Do you perceive that anyone in your family has **withdrawn or given up trying to work things out?**

Yes No If yes, who? _____

Circle your current level of **stress overall?** (No stress) 1 2 3 4 5 (extremely stressed)

Circle your current level of **stress in the family?** (No stress) 1 2 3 4 5 (extremely stressed)

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

1. _____
2. _____
3. _____

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

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

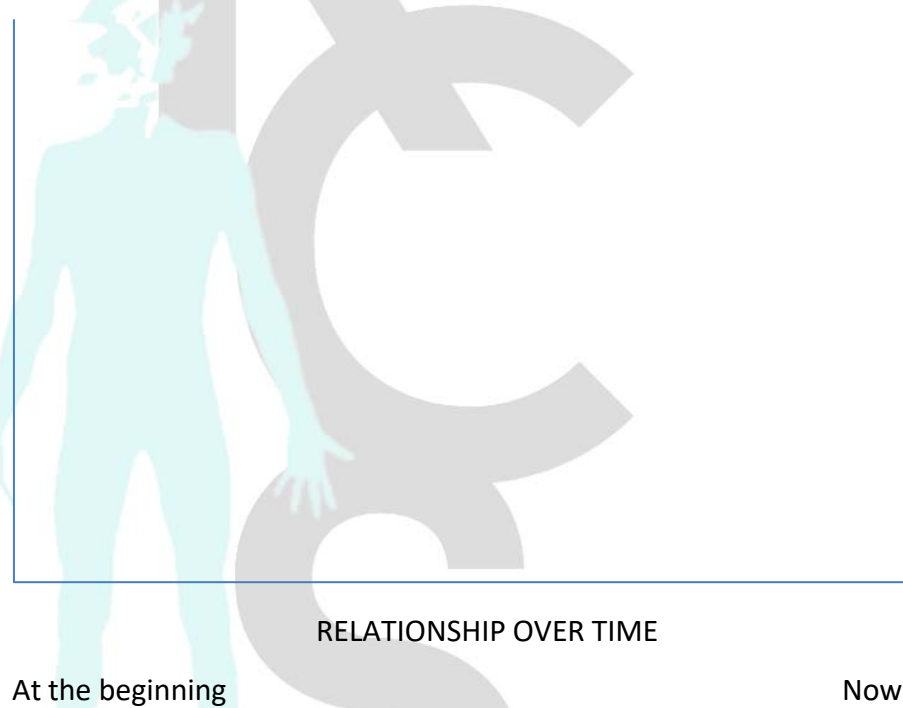
How willing are you to make "working on these relationships" a priority in your life?

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

Lastly, please **draw a graph indicating your level of family satisfaction** from the start until now. Mark significant events in your life (e.g., birth of a child, puberty, remarriage, etc.).

Complete satisfaction (100)

No satisfaction (0)



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 112 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 **booking of each session**, and sessions are to end no later than 10-minutes to the hour. Payments can be made by Cash, Bank transfer, or Google pay. **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) 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 by the Police with a written request, or (6) 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 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: _____

CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES: Client's Copy

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