Sandy Johnston
Empowering Counselling Services

INTAKE FORM and INFORMED CONSENT

Please provide the following information and answer the questions below.

Note: information you provide here is protected as confidential information.

Name: _____

(First) (Middle Initial) (Last)

Your Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Address:

_____

(Street and Number)

_____

(City) (Province) (Postal Code)

Home Phone: ( )_____May we leave a message? □ Yes □ No

Cell/Other Phone: ( )_____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Marital Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Name of Emergency Contact and contact number:

_____

Please list any children and their ages:

_____

Referred by (if any):

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

□ No □ Yes

If yes, please list including dosage:

_____

_____

Have you ever been prescribed psychiatric medication?

□ No □ Yes

If yes, please list and provide dates:

_____

_____

Have you experienced the death of a close loved one? What is the name of the deceased person and their relationship to you?

_____

What was the date and cause of death?

_____

_____

_____

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Informed Consent

Please check the therapeutic services that you are wish to obtain from Sandy Johnston

□ Individual Therapy □ Couples Therapy

□ Family Therapy □ Group Therapy

Sandy has discussed confidentiality within the therapeutic relationship including ***Duty to Report*** and ***Duty to Warn***. I fully understand what the limits of confidentiality are and accept these limitations.

□ Yes □ No

Name of Medical Doctor and Telephone Number: _____

I give Sandy permission to speak with any professional involved with my case in collaboration with my health and well-being.

□ Yes □ No

Sandy has discussed the cancellation policy with me and I am aware that I am required to give at least 48 hours' notice in the event that I cannot attend my scheduled appointment or the full fee will be charged.

_____ _____

Client's Signature and Date

_____ _____

Therapist's Signature and Date