THE COUNSELLING CORNER
CHILD, YOUTH & ADULT SERVICES

SASKATCHEWAN OFFICES
www.thecounsellingcorner.ca | 306-270-4178

CLIENT INFORMATION to be completed by all **new** and any **former** clients who have not been seen for 12 months or more.

Date : _____ (Month/Day/Year)

Primary Client(s) Full Name_____

Address
Street: _____ **City**: _____ **Postal**: _____

Home Phone : ( ) _____ Messages OK ? **Yes**___ **No**___

Work Phone : ( ) _____ Messages OK ? **Yes**___ **No**___

Other Phone : ( ) _____ Messages OK ? **Yes**___ **No**___

Age : ___ Date of Birth: _____ Gender: Male___ Female___

Occupation : _____ Years of Service : _____

Attending School : **Yes**___ **No**___ Name of School_____

Present Relationship Status :

Single___ Committed Relationship___ Common Law___ Married___ Separated___ Divorced___ Widowed___

Emergency contact name : _____ **Phone :** ( ) _____

Family Information: (Who you are residing with at this time. Ex. Mother, Father, Spouse, or Children).

Relationship	**Name**	**Age**
Mother		
Father		
Spouse		
Children		

Significant others if He/She required mention.
(e.g. brothers, sisters, grandparents, step-relatives, half-relatives, please specify relationship.)

<u>Please answer only the questions that apply, or that you are comfortable answering</u>. The facts of this form will be held in the strictest confidence. If you are filling this form out on behalf of someone else, answers should be from the client's perspective.

Personal History

Briefly describe what brought you here today. Some examples might be:
anger management, anxiety, depression, eating disorder, fear/phobias, loss or grief, self-esteem, suicide, self-injury, bullying, abuse, addictions, separation/divorce, parenting

_____

_____

_____

_____

_____

Approximately, how long have you had this concern ?
A Week___ A Month___ Months___ Years___

What are your goals for counselling?

_____

_____

What strengths and qualities do you admire about yourself?

_____

_____

Are there special, unusual, or traumatic circumstances that have affected your life?

_____

_____

_____

_____

Has there been history of child abuse? **Yes**___ **No**___

If Yes, which type(s)? **Sexual**___ **Physical**___ **Verbal**___

Medical/Physical Health

List any current health concerns:

_____

_____

Family history of medical problems:

_____

_____

_____

_____

Medication(s) and Reason for Medication(s)?

_____

_____

Physician's Name:

_____

Chemical Use History

Are you currently using any alcohol or drugs?
Yes___ **No**___

If yes, what are you using and how long have you been using?

_____

_____

Describe when and where you typically use substances:

_____

_____

Describe any changes in your use patterns:

_____

_____

Describe how your use has affected your family or friends (include their perceptions of your use):

_____

_____

_____

_____

Reason (s) for use : circle any that you feel apply
Addicted Build Confidence Escape Self-medication
Socialization Taste Other (specify):

_____

How do you believe your substance use affects your life?

_____

_____

_____

Who or what has helped you in stopping or limiting your use?

_____

_____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

Yes ___ No___

If yes, specify _____

_____

_____

_____

Have drugs or alcohol created a problem for your job/personal life ? **Yes___ No___**

If yes, specify_____

_____

_____

_____

_____

Counselling/Prior Treatment History

Are you seeing another counsellor at this time? **Yes___ No___**

Prior Counselling?
Yes___ No___

If Yes, specify _____

Current or Prior Psychiatric treatment?
Yes___ No___

If Yes, specify_____

Suicidal thoughts/attempts?
Yes ___ No___

If Yes, specify _____

Do you feel suicidal at this time?
Yes___ **No**___

If Yes, explain_____

Drug/alcohol treatment?
Yes___ **No**___

If Yes, specify _____

Hospitalizations?
Yes___ **No**___

If Yes, specify _____

Involvements with self-help groups ? (e.g. AA, Al-Anon, NA, etc)
Yes___ **No**___

If Yes, specify_____

_____

Any additional information that would assist in understanding your concerns or problems?

_____

_____

_____

_____

_____

Who referred you to The Counselling Corner?

Relative- Friend -Website - Facebook –Kijiji - Phone Book – Other

Counselling Costs will be paid personally by the client or by a parent at the time of each session and submitted by the client or parent to their own Insurance Provider or Employee Assistance Program.

FOR THOSE REQUESTING FEE REIMBURSEMENT FROM AN INSURANCE PROVIDER

While I understand that **some** Counsellors', Social Workers', or Psychologist' fees are reimbursable by **some** insurance programs, I also understand that:

- I am responsible for paying the Therapist's fee at the time of each session and submitting my claim personally,

- Neither the Therapist nor The Counselling Corner is responsible for denied claims,

-It is my responsibility to ensure that the Therapist I am seeing meets the criteria for my particular insurance policy,

-Obtaining such reimbursement is my personal responsibility, and is not the responsibility of my Therapist or The Counselling Corner,

CLIENT/THERAPIST AGREEMENT FOR PROVISION OF COUNSELLING SERVICES BETWEEN:

_____(the "Client") and_____(the "Therapist")

The Client agrees:

1. To provide prior notice of 24 hours if canceling an appointment. (Voicemail can be left anytime) **Failure to provide proper notice may result in a personal charge for the late cancellation.** Your prompt cancellation will permit someone else to the time and thus reduce the waiting periods for others;

2. To pay the Therapist's fees at end of each session. **If you are using an Employee Assistance Plan or Insurance Policy, you are responsible for paying the full fee and submitting your claim personally.**
   It is the Client's responsibility to ensure your Therapist meets the criteria for your specific Employee Assistance Plan or Insurance Policy. Neither the therapist nor The Counselling Corner is responsible for denied claims.

3. If you subpoena your therapist or anyone from The Counselling Corner, costs for court preparation, client rescheduling and court appearance(s) will be **paid by the client** at a rate of $180 per hour.

The Therapist agrees:

1. To provide counselling assistance based upon the Client's goals.

2. To maintain the confidentiality of the Client, unless:

a) You may be a danger to yourself or others, or there is a reasonable suspicion of child abuse or neglect. You recognize in such circumstances that I have a legal and ethical responsibility to my professional association to notify the proper authorities.

b) It is appropriate to consult with a professional colleague to improve the quality of my service to you; the information shared with this professional colleague will be kept anonymous and is restricted to the information necessary to aide in meeting your desired goals and to assist me in providing adequate service. This colleague will also be held to the rules of confidentiality.

c) You initiate a legal action whereupon I may use information from my records to defend myself.

By signing this Letter Agreement, I confirm that I have read and understand the terms set out above and that I agree to these terms. I also agree that this contract for the Provision of Counselling Services is between the Therapist listed below and myself. I also understand that my file will be destroyed within seven (7) years of my last visit.

Client's Full Name : (Print) _____

Address _____Phone _____

Therapist : (Print)

_____

Therapist's Signature:

_____**Date :**_____