INTAKE FORM

Please provide the following information and answer the questions below.
Please note: The information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: ____
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: _________ Gender: ☐ Male ☐ Female
mm dd yr

Marital Status:
☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children/ages: ____

Address: ____
(Street and Number)

____
(City) (Province) (PC)

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 I would like to receive a Newletter email ? ☐ Yes ☐ No

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

Referred by (if any): ____

Have you previously received any type of mental health services (psychotherapy, psychiatric services?
☐ No
☐ Yes, previous therapist/practitioner: ____

Are you currently taking any prescription medication?
☐ Yes
☐ No

Please list:
____

____

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

Please list and provide dates: ____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. 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:

____

2. 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:

____

3. How many times per week do you generally exercise? ______________________________________

What types of exercise to you participate in: ____

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

____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? ____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? ____

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

If yes, please describe ____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? ____

On a scale of 1-10, how would you rate your relationship? ___________________________________

11. What significant life changes or stressful events have you experienced recently, if any?

____

____

____

____

Check Any of the Following That May Apply to You:

□ Headache	□ Inferiority Feelings	□ Shy With People
□ Dizziness	□ Feel Tense	□ Can't Make Friends
□ Fainting Spells	□ Feel Panicky	□ Afraid Of People
□ No Appetite	□ Fears and Phobias	□ Home Conditions Bad
□ Over-Eating	□ Obsessions	□ Unable To Have A Good Time
□ Stomach Trouble	□ Depressed	□ Always Worried About Something
□ Bowel Disturbances	□ Suicidal Ideas	□ Don't Like Weekends/Vacations
□ Always Tired	□ Take Tranquilizers	□ Can't Make Decisions
□ Always Sleepy	□ Alcoholism	□ Over-Ambitious
□ Unable To Relax	□ Dangerous Drugs	□ Financial Problems
□ Insomnia	□ Allergy	□ Gambling
□ Recurrent Dreams	□ Asthma	□ Job Problems
□ Nightmares	□ Homosexuality	□ Can't Keep A Job
□ Hallucinations	□ Sexual Problems	□ Other ____________

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	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

____

3. What do you consider to be some of your strengths?

____

____

____

____

4. What do you consider to be some of your weakness?

____

____

____

____

5. On a scale of 1 to 10 how satisfied are you with your overall life? ____________________________

6. What would you like to accomplish out of your time in therapy?

____

____

____

____

7. What is your primary reason for wanting to begin or pursuing therapy?

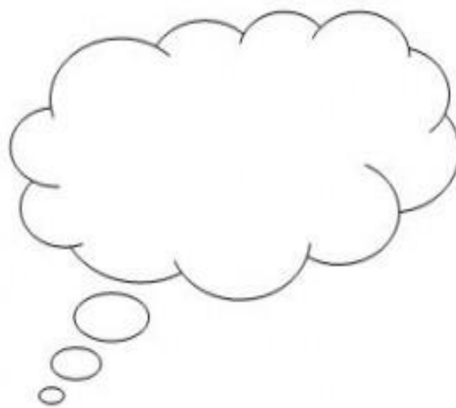
____

____

____

____

8. What is your most dominant thought pattern that you are aware of?



BAYSIDE WELLNESS

Consent to Psychotherapy Services

SHEILA I BRISTOW

Your signature below confirms you fully understand, accept, comprehend, and acknowledge the following terms of service and agree to its terms on your own free will.

THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS AND LIABILITIES, PLEASE READ CAREFULLY ASKING ANY QUESTIONS YOU MAY HAVE.

AGREEMENT & CONSENT TO PSYCHOTHERAPY TREATMENT

I, ____

HEREBY ACKNOWLEDGE THAT SHEILA BRISTOW:

- □ Is a Registered Psychotherapist (RP#6786) with the College of Registered Psychotherapist of Ontario.
- □ May assess me and that her services include individual, couple, family, and/or group psychotherapy.
- □ Cannot provide or evaluate medication or complete a psychological assessment.
- □ Works from a variety of therapeutic interventions, depending on your goals and/or concerns.

HEREBY ACKNOWLEDGE THAT:

- □ Therapy cannot guarantee results.
- □ There are many different methods that may be used in psychotherapy and they have benefits and risks.
- □ Therapy incorporates talking and feeling aspects of your life that may make you feel uncomfortable.
- □ Changes you make as a result of being in therapy may impact your relationships.
- □ Services are voluntary and you are free to limit or end services at any time.
- □ All information collected in the course of our work together will be held in strict confidence.
- □ Often clients discontinue therapy after one session for a variety of reasons; I acknowledge that is acceptable that Sheila Bristow may follow up with me by email to check in.
- □ Periodically, I will seek clinical consultation with another professional. No names or specific identifying information will be released, and the consultant is also legally bound to keep information confidential.
- □ **There are certain circumstances where I am obligated by law to break confidentiality:**
  - **If I believe you or someone else is at risk of harm to themselves or to another person;**
  - **If a child under the age of 16 is <u>at risk</u> of harm;**
  - **If I am subpoenaed by a court order or presented with a search warrant.**
- □ We live in a small rural community which has potential implications such as:
  - You may see me in a public setting. In order to protect your confidentiality, I will **<u>not</u>** acknowledge you as a client in public. That being said, you are absolutely welcome to greet me.
  - Social Media is now a big part of how we all connect. We cannot be **<u>'friends'</u>** on any social media platforms, to protect your confidentiality; however if you choose to <u>follow</u> any of my social media accounts, that is acceptable.
  - We may enter into a dual relationship which is when we have more than one type of relationship. Your safety is always my priority and our therapeutic relationship would not be acknowledged to ensure your confidentiality and safety. Should we enter into a dual relationship, we will discuss the potential implications associated with a dual relationship.
- □ Fees are due with each session. Missed appointments or cancellations with less than 24 hours notice will be billed at my regular hourly rate.
- □ You may contact me through email or phone. Please know that email **<u>is not</u>** a secure way of communicating.
- □ As I am not always available, I may not be able to respond to crisis situations. Should a crisis occur, please contact the nearest hospital emergency room or call 9-1-1.

_______________________________ _______________________________

Client's Signature Date

CONFIDENTIAL